STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPI	LETED
		15G447	B. WIN		01/21	01/21/2015	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	2			NOLLTON RD		
VOCA CO	ORPORATION OF	INDIANA			APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000000							
		or an investigation of	W0	00000			
	complaint #IN00)162396.					
	This visit was in conjunction with the						
		n revisit (PCR) survey to					
	•	n and state licensure					
	survey completed on 11/12/14.						
	C. Lind III Dicol (2004)						
	Complaint #IN00162396: Substantiated,						
	Federal and state deficiencies related to						
	the allegation(s)	are cited at W102,					
	W104, W122, W	/149, W154, W157,					
	W240 and W331						
	,, = 10 min ,, 55 ;	•					
	Survey dates: Is	anuary 13, 14, 15 and 21,					
	_	muary 13, 14, 13 and 21,					
	2015						
	Facility Number						
	Provider Numbe	er: 15G447					
	AIM Number: 1	.00244750					
	Surveyor:						
	Paula Eastmond,	OIDP-TC					
	Tudia Dasanona,	, , , , , , , , , , , , , , , , , , , ,					
	Those deficients	es also reflect state					
	_	rdance with 460 IAC 9.					
	· •	completed 1/27/15 by					
	Ruth Shackelfor	d, QIDP.					
							I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000961

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building			COMPL	COMPLETED	
		15G447	B. WING 01/21/2015			2015		
			D. 17111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER	-	4114 KNOLLTON RD					
VOCA CO	ORPORATION OF I	NDIANA			APOLIS, IN 46228			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
W000102	483.410 GOVERNING BOIL The facility must e governing body ar requirements are r Based on observer record review, the the Condition of Governing Body clients (B and C) client (H). The ensure the facilit C, conducted the regard to neglect unknown source and to ensure con were taken to pro- Findings include 1. The governing the facility met the Participation: Cl 4 sampled clients additional client body failed to en implemented its procedures to pro- in regard to falls failed to ensure t thorough investig allegations of ab- injuries of unknown C and H. The governing C and	DY AND MANAGEMENT insure that specific and management met. ation, interview and the facility failed to meet in Participation: for 2 of 4 sampled and for 1 additional governing body failed to by did not neglect client brough investigations in and/or injuries of for clients B, C and H, the facility measures/actions of the client C from falls. End body failed to ensure the Condition of lient Protections for 2 of the fall of the condition of the	Wo	00102	CORRECTION: The facility must ensure that specific governing body and managem requirements are met. Specifically, the governing bodh has facilitated the following: The investigation into Client H discovered injury on 11/5/14 h been located. The Residential Manager responsible for failing to complet thorough investigations of Client C's falls and Client B, C and H's injuries of unknown origin has been removed from the facility and no longer serves in a formal supervisory capacity. ADDENDUM 2/17/15: The Operations Team, including the Program Manager and QIDP, will directly oversee a investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The governing Bod will assume complete responsibility for investigating any discovered	dy 's as ee	02/20/2015	
	· '		1		1			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/21/2015			
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE			
	ORPORATION OF	INDIANA	4114 KNOLLTON RD INDIANAPOLIS, IN 46228				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) SEE COMPLETION DATE		
TAG	actions/measures falls which occur Please see W122 2. The governing the facility implead procedures to client in regard to prevent potential client C. The government of the facility written policy are thorough investial allegations of abinjuries of unknown C and H, and to measures were pregard to monitor. The governing befacility conducted investigations in possible neglect unknown source. The governing befacility put in plato prevent client bathroom. Please	is for client C in regard to rred in the bathroom. In g body failed to ensure emented its written policy to prevent neglect of the of alls in the bathroom to a falls and injuries for everning body failed to the ensure to conduct gations in regard to the ensure corrective for clients B, the ensure corrective for the end thorough the end to allegations of and/or injuries of for clients B, C and H. ody failed to ensure the ensure the end to e	TAG	injuries that require outsice medical treatment. When evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Client C has begun receiving twice weekly physical therapy sessions and a daily home exercise program has been initiated to enhance Client C's core strength to diminish the incidence of falls such as occurred on 12/12/14 and 12/15/14. An Occupational Therapy evaluation has been scheduled for Client C to evaluate effectiveness of current adaptive equipment and to obtracommendations for enhancements. In the interima after appropriate due process, the team will provide the following adaptive modification the seat belt will be re-fitted to client C's wheelchair and a chalarm will be installed to alert staff when the seat belt has become unfastened. Client C receive enhanced supervision—line of sight observation and minute checks while in her bedroom. A bed alarm and au	DATE de any ce e e e e e e e e e e e e e e e e e e		
				monitor will be placed in her			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MUI			ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		15G447	B. WIN			01/21/	2015
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t.	4114 KNOLLTON RD				
	ORPORATION OF I	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·		DATE
					bedroom. The team will also		
					provide a modified toilet seat with side rails. The nurse will		
					modify Client C's Comprehensive		
					High Risk Plan for falls to clarify		
					the expectations for "stand by"		
					assistance while Client C is in the	2	
					bathroom including but not		
					limited to hands on use of a gait		
					belt at all time while client C is		
					toileting and showering.		
					PREVENTION:		
					PREVENTION.		
					ADDENDUM 2/17/15: A		
					tracking spreadsheet for		
					incidents requiring		
					investigation, follow-up and		
					corrective/protective		
					measures will be maintained		
					and distributed daily to		
					facility supervisors and the		
					Operations Team. The Clinica	al	
					Supervisor (Administrative		
					level management) will mee		
					with his/her facility management teams weekly		
					to review the progress made		
					on all investigations that are		
					open for their homes.		
					Residential Managers will be		
					required to attend and sign		
					an in-service at these		
					meetings stating that they		
					are aware of which		
					investigations with which		
					they are required to assist, a	s	
					well as the specific		
			1				

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/21/2015		
NAME OF P	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD				
VOCA CO	DRPORATION OF	INDIANA	INDIAN	IAPOLIS, IN 46228			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON (X5) BE COMPLETION PRIATE DATE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	components of the investigation for which the are responsible, within the five business day timefrar The Clinical Supervisor wince weach investigation ensure that they are thorough—meeting regulatory and operational standards, and will not designate an investigation completed, if it does not not these criteria. The Program Manager will also conduct spot checks of investigation focusing on serious incided that could potentially have occurred as a result of standards updates to the Program Manager on the status of investigations. Failure to complete thorous investigations within the allowable five business day timeframe will result in progressive corrective act to all applicable team members. The Residential Manager will develop and maintain a staffin matrix that assures adequated direct support staff who possible team who investigation that could be supported that the staffin matrix that assures adequated direct support staff who possible team who is the support staff who possible team direct support staff who possib	ey e me. II to II n, as neet m t ons, ents e ff		
				the training, skills and capabi to provide appropriate active treatment and assure the hea			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G447			(X2) MULTIPLE CO A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 01/21/2015		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				and safety of clients at all times. Members of the Operations Tear and the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 1 Days, and no less than twice weekly for an additional 60 Days At the conclusion of this period intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will focus on mentorship and training of supervisory staff, monitoring and coaching of diresupport staff, and evaluation of the effectiveness of current risk plans and safety protocols. RESPONSIBLE PARTIES QIDP, Residential Manager, Team Leader, Operations Tea	n e e e e e e e e e e e e e e e e e e e		
W000104		DY dy must exercise general d operating direction over					
	Based on observed record review for (B and C) and for the governing because general policy and over the facility	ation, interview and r 2 of 4 sampled clients or 1 additional client (H), ody failed to exercise and operating direction to ensure the facility did t C, conducted thorough	W000104	body must exercise general policy, budget, and operating direction over the facility. Specifically, the governing both has facilitated the following: The investigation into Client Hidiscovered injury on 11/5/14 hibeen located.	dy 's		

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STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPL	ETED
		15G447	B. WIN			01/21/	2015
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	t			NOLLTON RD		
VOCA CO	ORPORATION OF	ΙΝΠΙΔΝΑ			APOLIS, IN 46228		
					7 (1 OLIO, IIV 40220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	_	regard to neglect and/or			The Residential Manager responsible for failing to complet		
	-	own source for clients B,			thorough investigations of Client		
	· ·	ensure corrective			C's falls and Client B, C and H's		
	measures/actions	s were taken to protect			injuries of unknown origin has		
	client C from fal	ls.			been removed from the facility		
					and no longer serves in a formal		
	Findings include	•			supervisory capacity.		
	i mamga maraac	•			ADDENDUM 2/17/15: The		
	1 The governir	ag body failed to avaraise			Operations Team, including		
	_	ng body failed to exercise			the Program Manager and		
		nd operating direction			QIDP, will directly oversee a	II	
	1	to ensure the facility			investigations. The		
	implemented its written policy and				Residential Manager will		
	procedures to pro	event neglect of the			receive additional training		
	client in regard t	o falls in the bathroom to			toward assisting with	_	
	prevent potential	I falls and injuries for			gathering evidence, including conducting thorough witness	_	
	client C. The go	overning body failed to			interviews. The Clinical	•	
	_	policy and operating			Supervisor and Program		
	_	e facility to ensure the			Manager will assure that		
		nted its written policy			conclusions are developed		
		to conduct thorough			that match the collected		
	-	regard to allegations of			evidence. The governing Bod	ly	
	_	-			will assume complete		
		nd/or injuries of unknown			responsibility for investigating any discovered		
		s B, C and H, and to			injuries that require outside		
		e measures were put in			medical treatment. When an	,	
	_	C in regard to monitoring			evidence of staff negligence	,	
	and supervision.	Please see W149.			is uncovered or alleged the		
					Operations Team will take		
	2. The governin	g body failed to exercise			control of all aspects of the		
	general policy as	nd operating direction			investigation process.		
		to ensure the facility					
	_	ugh investigations in					
		ions of possible neglect					
	_	f unknown source for					
	_				Client C has begun receiving		
	chents B, C and	H. Please see W154.	1		S. S. C. C. Has began receiving		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	MMC	00	COMPLI	ETED
		15G447	B. WING 01/21/2015				2015
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	₹			NOLLTON RD		
VOCA C	ORPORATION OF	INIDIANIA					
VOCA C	URPURATION OF	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
					twice weekly physical therapy		
	3 The governing	og body failed to exercise			sessions and a daily home		
	3. The governing body failed to exercise general policy and operating direction				exercise program has been		
	1				initiated to enhance Client C's		
	over the facility	to put in place corrective			core strength to diminish the		
	measures to prev	vent client C from falling			incidence of falls such as		
	in the bathroom.	Please see W157.			occurred on 12/12/14 and		
					12/15/14. An Occupational		
	This federal tag	relates to complaint			Therapy evaluation has been		
	#IN00162396.				scheduled for Client C to evaluate	e	
	#11N00102390.				the effectiveness of current	·	
					adaptive equipment and to obtai	n l	
	9-3-1(a)				recommendations for		
					enhancements. In the interim,		
					after appropriate due process,		
					the team will provide the		
					following adaptive modifications:		
					the seat belt will be re-fitted to		
					Client C's wheelchair and a chair		
					alarm will be installed to alert		
					staff when the seat belt has		
					become unfastened. Client C will		
					receive enhanced supervision		
					-line of sight observation and 15	:	
					minute checks while in her		
					bedroom. A bed alarm and audio		
					monitor will be placed in her	' 	
					bedroom. The team will also		
					provide a modified toilet seat with side rails. The nurse will		
					modify Client C's Comprehensive		
					High Risk Plan for falls to clarify		
					the expectations for "stand by"		
					assistance while Client C is in the	;	
					bathroom including but not		
					limited to hands on use of a gait		
					belt at all time while client C is		
					toileting and showering.		

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/21/2015		
	ROVIDER OR SUPPLIER DRPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON (X5) BE COMPLETION DATE		
			PREVENTION: ADDENDUM 2/17/15: A tracking spreadsheet for incidents requiring investigation, follow-up a corrective/protective measures will be maintain and distributed daily to facility supervisors and the Operations Team. The Clin Supervisor (Administrative level management) will make to review the progress make to attend and signal investigations that the are aware of which investigations with which they are required to assiss well as the specific components of the investigation for which they are responsible, within the five business day timeframed the they are that they are thorough —meeting regulatory and operations standards, and will not designate an investigation completed, if it does not rethe they are they are thorough and operations standards, and will not designate an investigation completed, if it does not rethe they are criteria. The Programmed the Programmed the Programmed the Programmed they are they are thorough and operations standards, and will not designate an investigation completed, if it does not rethe they are criteria. The Programmed they are the	ned ne nical ne nical ne neet neet nly nde nare be nn y t, as ey e nne. Il to nl n, as neet		

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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/21/2015		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team				4114 KNOLLTON RD				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG	VOCA CO	DRPORATION OF	INDIANA	INDIAN	IAPOLIS, IN 46228			
spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	N BE COMPLETION PRIATE		
The Residential Manager will develop and maintain a staffing matrix that assures adequate direct support staff who possess the training, skills and capabilities to provide appropriate active treatment and assure the health and safety of clients at all times. Members of the Operations Team and the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	Manager will also conduct spot checks of investigation focusing on serious incided that could potentially have occurred as a result of state negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorou investigations within the allowable five business datimeframe will result in progressive corrective actional applicable team members. The Residential Manager will develop and maintain a staffir matrix that assures adequate direct support staff who posses the training, skills and capabil to provide appropriate active treatment and assure the heal and safety of clients at all time. Members of the Operations Teand the QIDP will conduct act treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional Days, and no less than twice weekly for an additional 60 Days, and no less than twice weekly for an additional for the conclusion of this period intensive administrative	ons, nts e ff Igh y ion ng ess ities lth es. eam ive s 1 14 ays.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED		
		15G447	B. WING	-	01/21/2015
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R	4114 K	NOLLTON RD	
VOCA C	ORPORATION OF	INDIANA		IAPOLIS, IN 46228	
(X4) ID	CHMMADVS	TATEMENT OF DEFICIENCIES	ID	<u>.</u> 1	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	` '
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
W000122	483.420 CLIENT PROTEC			Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will focus on mentorship and training of supervisory staff, monitoring and coaching of direct support staff, and evaluation of the effectiveness of current risk plans and safety protocols. RESPONSIBLE PARTIES QIDP, Residential Manager, Team Leader, Operations Tea	et :
	protections required Based on observer record review that the Condition of Protections for 2 and C) and for 1. The facility failed written policy and reglect of client facility failed to investigations in of abuse, neglect unknown sources. The facility failed measures were protected to the second protection of the facility failed measures were protected to the second protected to the facility failed measures were protected to the second protected to the facility failed measures were protected to the facility failed measures were protected to the facility failed to the facility failed measures were protected to the facility failed to th	vation, interview and the facility failed to meet if Participation: Client if Of 4 sampled clients (B) additional client (H). The deto implement its and procedures to prevent if C in regard to falls. The conduct thorough a regard to all allegations at and/or injuries of the for clients B, C and H. The deto ensure corrective the put in place for client C in which occurred in the	W000122	CORRECTION: The facility must ensure that specific client protections requirements are in Specifically: The facility has located the investigation into Client H's discovered injury or 11/5/14. The Residential Manager responsible for failing to complet thorough investigations of Client C's falls and Client B, C and H's injuries of unknown origin has been removed from the facility and no longer serves in a formal supervisory capacity. ADDENDUM 2/17/15: The Operations Team, including the Program Manager and QIDP, will directly oversee a investigations. The Residential Manager will receive additional training toward assisting with	met.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G447		(X2) MUL ^o A. BUILDI B. WING		00	(X3) DATE S COMPLE 01/21/2	ETED	
	PROVIDER OR SUPPLIER			4114 KN	DDRESS, CITY, STATE, ZIP CODE IOLLTON RD APOLIS, IN 46228		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	written policy and neglect of the clithe bathroom to and injuries for cliented to implem procedures to co investigations in abuse, neglect are source for cliented ensure corrective place for client cliented and supervision. 2. The facility fainvestigations in possible neglect	regard to allegations of ad/or injuries of unknown is B, C and H, and to emeasures were put in C in regard to monitoring Please see W149. Alled to conduct thorough regard to allegations of and/or injuries of for clients B, C and H.			gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The governing Bod will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When an evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process.	s ly	
	corrective measu from falling in th W157.	niled to put in place tres to prevent client C tres to bathroom. Please see trelates to complaint			Client C has begun receiving twice weekly physical therapy sessions and a daily home exercise program has been initiated to enhance Client C's core strength to diminish the incidence of falls such as occurred on 12/12/14 and 12/15/14. An Occupational Therapy evaluation has been scheduled for Client C to evaluat the effectiveness of current adaptive equipment and to obtain recommendations for enhancements. In the interim, after appropriate due process, the team will provide the		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447		A. BUILDING B. WING		COMPLETED 01/21/2015	
	ROVIDER OR SUPPLIER		STREET A 4114 KI	ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD APOLIS, IN 46228	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) OBE PRIATE COMPLETION DATE
				following adaptive modification the seat belt will be re-fitted Client C's wheelchair and a control alarm will be installed to aler staff when the seat belt has become unfastened. Client C receive enhanced supervision—line of sight observation and minute checks while in her bedroom. A bed alarm and a monitor will be placed in her bedroom. The team will also provide a modified toilet seat with side rails. The nurse will modify Client C's Comprehen High Risk Plan for falls to clait the expectations for "stand be assistance while Client C is in bathroom including but not limited to hands on use of a belt at all time while client C toileting and showering.	to hair t will n d 15 udio sive rify y" n the gait
				PREVENTION:	
				ADDENDUM 2/17/15: A tracking spreadsheet for incidents requiring investigation, follow-up a corrective/protective measures will be maintain and distributed daily to facility supervisors and the Operations Team. The Clis Supervisor (Administrativel level management) will newith his/her facility management teams week	ned ne nical re neet

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLE 01/21/2	TED		
	ROVIDER OR SUPPLIE DRPORATION OF		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE OPRIATE	(X5) COMPLETION DATE		
				to review the progress mon all investigations that open for their homes. Residential Managers will required to attend and si an in-service at these meetings stating that the are aware of which investigations with which they are required to assist well as the specific components of the investigation for which they are responsible, within the five business day timefrated The Clinical Supervisor was review each investigation ensure that they are thorough—meeting regulatory and operation standards, and will not designate an investigation completed, if it does not these criteria. The Program Manager will also conduct spot checks of investigations focusing on serious incided that could potentially has occurred as a result of standards are sult of standards of investigations. Failure to complete thorous investigations within the allowable five business of timeframe will result in progressive corrective actional applicable team	tare Il be gn ey h st, as hey he ime. vill n to aal on, as meet am ct ions, ents ve aff			

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
I TO I LIM	or conduction	15G447	A. BUILDING		01/21/2015	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIER			NOLLTON RD		
VOCA C	ORPORATION OF I	NDIANA		IAPOLIS, IN 46228		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
				members.		
				The Residential Manager will		
				develop and maintain a staffing		
				matrix that assures adequate direct support staff who possess		
				the training, skills and capabilities		
				to provide appropriate active		
				treatment and assure the health	1	
				and safety of clients at all times		
				Members of the Operations Teal		
				and the QIDP will conduct active treatment observations and	9	
				documentation reviews no less		
				than five times weekly for the		
				next 21 days, no less than 3		
				times weekly for an additional 1	4	
				Days, and no less than twice	_	
				weekly for an additional 60 Days At the conclusion of this period		
				intensive administrative	01	
				monitoring and support, the		
				Operations Team will determine		
				the level of ongoing support		
				needed at the facility.		
				Administrative support at the home will focus on mentorship		
				and training of supervisory staff		
				monitoring and coaching of dire		
				support staff, and evaluation of		
				the effectiveness of current risk		
				plans and safety protocols. RESPONSIBLE PARTIES	<u>.</u>	
				QIDP, Residential Manager,	-	
				Team Leader, Direct Support		
				Staff, Operations Team		
W000149	483.420(d)(1)					
	.30. 120(0)(1)					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPL	ETED	
		15G447	B. WIN			01/21/	/2015	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER	8			NOLLTON RD			
VOCA C	ORPORATION OF	INDIANA			IAPOLIS, IN 46228			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	STAFF TREATME							
		levelop and implement Id procedures that prohibit						
	mistreatment, neglect or abuse of the client.							
	· -	ration, interview and	wo	00149	CORRECTION: The facility		02/20/2015	
		or 2 of 4 sampled clients	'''	001.9	must develop and implement		02/20/2016	
		or 1 additional client (H),			written policies and procedure			
	` /	ected to implement its			that prohibit mistreatment, neg			
		nd procedures to prevent			or abuse of the client. Specific The facility has located the	ally:		
					investigation into Client H's			
		ient in regard to falls in			discovered injury on 11/5/14.			
	the bathroom to prevent potential falls and injuries. The facility neglected to				The Residential Manager			
					responsible for failing to complet	te		
	implement its wi				thorough investigations of Client			
	procedures to co	nduct thorough			C's falls and Client B, C and H's			
	investigations in	regard to allegations of			injuries of unknown origin has			
	abuse, neglect ar	nd/or injuries of unknown			been removed from the facility			
	source for clients	s B, C and H, and to			and no longer serves in a formal supervisory capacity.			
	ensure corrective	e measures were put in			ADDENDUM 2/17/15: The			
	place for client (C in regard to the client's			Operations Team, including			
	falls.	C			the Program Manager and			
					QIDP, will directly oversee a	II		
	Findings include	<u>.</u>			investigations. The			
	1 manigs merade	··			Residential Manager will			
	1 During the 1/	13/15 observation period			receive additional training			
	_	M and 6:45 PM and the			toward assisting with	_		
					gathering evidence, including conducting thorough witness	_		
		tion period between 6:14			interviews. The Clinical	•		
		M, at the group home,			Supervisor and Program			
		a wheelchair for			Manager will assure that			
		lient C did not wear a			conclusions are developed			
		the wheelchair. Client C			that match the collected	_		
	_	around the client's waist.			evidence. The governing Bod	ly		
	Specifically duri	ing the 1/13/15			will assume complete			
	observation perio	od, client C sat forward			responsibility for investigating any discovered			
	on the edge of w	heelchair seat. Client C			injuries that require outside			
	_	irected to sit/scoot back			medical treatment. When an			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			ĺ		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		15G447	B. WIN			01/21/2015	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
V004 0		INIDIANIA			NOLLTON RD		
VOCA CO	ORPORATION OF I	INDIANA		INDIAN	IAPOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	,	DATE	
		r and to sit up straight.			evidence of staff negligence		
	_	15 observation period,			is uncovered or alleged the		
	•	re were 2 direct care staff			Operations Team will take control of all aspects of the		
	(staff #4 and #6)	and the group home			investigation process.		
	manager (staff#	1) at the group home.					
	Staff #6 was assi	sting clients to get up					
	and get dressed a	and staff #1 was assisting					
	client #8 to prepa	are breakfast. Staff #4					
		eation room passing the			Client C has begun receiving		
	morning medica	tions. Staff #4 stayed in			twice weekly physical therapy		
	the medication re	•			sessions and a daily home		
		od except to come out of			exercise program has been		
	_	oom to get clients for her			initiated to enhance Client C's		
		tions. Staff #4 did not			core strength to diminish the		
	_	eakfast meal when			incidence of falls such as		
					occurred on 12/12/14 and		
		getting medications.			12/15/14. An Occupational Therapy evaluation has been		
		nasal oxygen tube while			scheduled for Client C to evaluate	<u>a</u>	
		ble oxygen container with			the effectiveness of current		
	her. During the				adaptive equipment and to obtain	n	
	•	od, client C required			recommendations for		
		physical assistance when			enhancements. In the interim,		
	_	her wheelchair to the			after appropriate due process,		
		physically assisted client			the team will provide the following adaptive modifications:		
		grabbing the client's gait			the seat belt will be re-fitted to		
	belt to steady the	e client during the			Client C's wheelchair and a chair		
	transfer. Client	•			alarm will be installed to alert		
	assistance when	walking as the client was			staff when the seat belt has		
	blind. Client E r	equired staff physical			become unfastened. Client C will		
	assistance as wel	ll when ambulating as the			receive enhanced supervision		
		ker and wore a gait belt			-line of sight observation and 15		
		ient B required staff			minute checks while in her bedroom. A bed alarm and audio	,	
		monitoring due to the			monitor will be placed in her		
	-	of trying to get into the			bedroom. The team will also		
	kitchen to drink				provide a modified toilet seat		
	Attended to dillik						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		15G447	1	LDING		01/21/	2015
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
		IN ID LANGE			NOLLTON RD		
VOCA CO	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					with side rails. The nurse will		
	The facility's rer	ortable incident reports			modify Client C's Comprehensive	!	
	The facility's reportable incident reports, the facility's internal Incident/Accident				High Risk Plan for falls to clarify		
	1				the expectations for "stand by"		
		and/or investigations			assistance while Client C is in the	9	
	were reviewed o	n 1/14/15 at 11:17 AM.			bathroom including but not		
	The facility's rep	oortable incident reports,			limited to hands on use of a gait		
	IARs and/or invo	estigations indicated the			belt at all time while client C is		
	following (not all inclusive):				toileting and showering.		
	lone wing (not us	ii iiiciusive).					
	11/11/14 977						
	-11/11/14 "Upon arrival to group home						
		dividual Supported by			PREVENTION:		
	Rescare) had jus	t been assisted off the					
	van and into the	group home by staff. As			ADDENDUM 2/17/15: A		
	the staff continu	ed to assist the other			tracking spreadsheet for		
		ne van (sic) [client C]			incidents requiring		
		into the bathroom			investigation, follow-up and		
					corrective/protective measures will be maintained	ı	
	_	omeone to assist her.			and distributed daily to		
		was in the bathroom she			facility supervisors and the		
	proceeded to tak	e off her brief and pants			Operations Team. The Clinica	si.	
	causing her to fa	ll to her knees causing an			Supervisor (Administrative	41	
	_	diameter injury to the			level management) will mee		
		area was cleaned with			with his/her facility		
					management teams weekly		
		itment applied to the area			to review the progress made	1	
		n bandaide (sic)[Client			on all investigations that are		
	C] has a high ris	k plan for falls in place			open for their homes.		
	and staff will con	ntinue to implement her			Residential Managers will be	1	
	plan and give he	r moral support. The			required to attend and sign		
	_	team will be meeting to			an in-service at these		
		ways to ensure [client			meetings stating that they		
		ways to ensure [enemt			are aware of which		
	C's] safety."				investigations with which		
					they are required to assist, a	s	
	-12/12/14 "As I	(staff #5) brushed [client			well as the specific		
	C's] head she wa	s complaining of pain on			components of the		
	her head where I	brushed. I asked her			investigation for which they		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	DDIC	00	COMPLI	ETED
		15G447		LDING		01/21/2	2015
			B. WIN		ADDRESS SITE STATE SID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
V004 0		INIDIANIA			NOLLTON RD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	IAPOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	what was wrong	(sic) she stated that she			are responsible, within the		
	fell as she got ur	o off the toilet and hit her			five business day timeframe.		
	head on the toilet seat." The IAR				The Clinical Supervisor will		
	indicated "There is a scratch that is a				review each investigation to		
	(sic) inch long it is red and sore to the				ensure that they are		
	` ′	is red and sore to the			thorough -meeting		
	touch (sic)."				regulatory and operational		
					standards, and will not		
	The facility's 12/31/14 follow-up report				designate an investigation, a		
	to the 12/12/14 reportable incident report				completed, if it does not mee	et	
	indicated "[Client C's] injury has healed				these criteria. The Program		
	and no further medical treatment was				Manager will also conduct	_	
					spot checks of investigations focusing on serious incidents		
		g the investigation it was			that could potentially have	'	
	-	e staff that worked that			occurred as a result of staff		
	evening [client (C] was assisted to the			negligence. The Clinical		
	bathroom into he	er bed with no injuries			Supervisors will provide		
	occurring that ev	vening. [Client C]			weekly updates to the		
		at she had fell (sic) and			Program Manager on the		
		ber when she fell. Staff			status of investigations.		
					Failure to complete thorough	ո	
	_	ed on [client C's] high			investigations within the		
	_	s and will monitor [client			allowable five business day		
	C] more closely.	."			timeframe will result in		
					progressive corrective action	ı	
	The facility's 12	/12/14 attached witness			to all applicable team		
	statements/inves	tigation in regard to the			members.		
		vn source indicated only					
	" "	If were interviewed in					
					The Decidential March		
		C's injuries. The staffs'			The Residential Manager will		
	witness statemer	its indicated the			develop and maintain a staffing		
	following:				matrix that assures adequate direct support staff who possess		
					the training, skills and capabilitie		
	-Staff #7 was int	erviewed on 12/12/14.			to provide appropriate active	3	
	Staff #7's witness statement indicated				treatment and assure the health		
		all at least I don't think			and safety of clients at all times.		
					Members of the Operations Tear		
	i sne aia. I aian't	take her and usually she	1		I remocis of the operations real	"	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G447	B. WING		01/21/2015
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEI	₹		NOLLTON RD	
VOCA C	ORPORATION OF	INDIANA		NAPOLIS, IN 46228	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LISC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		she fell. She would like		and the QIDP will conduct active	e
	(sic) 'I fall, I fall	'."		treatment observations and documentation reviews no less	
				than five times weekly for the	
	-Staff #8 was in	terviewed on 12/12/14.		next 21 days, no less than 3	
	Staff #8's witness statement indicated			times weekly for an additional 1	4
	"She didn't fall.	I assisted her to the		Days, and no less than twice	
	bathroom. I ass	isted on the toilet and off		weekly for an additional 60 Day	
	and into bed. N	o she didn't fall cause if		At the conclusion of this period	of
		d of (sic) needed to assist		intensive administrative	
	her up together." The facility's 12/12/14 investigation indicated the facility attempted to			monitoring and support, the	
				Operations Team will determine the level of ongoing support	
				needed at the facility.	
				Administrative support at the	
		lients who lived in the		home will focus on mentorship	
				and training of supervisory staff	,
		ne facility's investigation		monitoring and coaching of dire	
		H was interviewed on		support staff, and evaluation of	
		PM. Client H's witness		the effectiveness of current risk	
		ted "I didn't actually see		plans and safety protocols. RESPONSIBLE PARTIES	
	3.	ient C] on the toilet. I		QIDP, Residential Manager,	·
) her [staff #7] bring		Team Leader, Direct Support	
	[client C] to the	bathroom and put her on		Staff, Operations Team	
	the toilet and tol	d her not to move and			
	[client C] got up	on her own and fell. I			
	was in the living	g room and heard [client			
		see anything. I was in			
	the living room.	" The facility's			
	_	glected to indicate any			
		v-up interviews and/or			
		conducted in regard to			
	1 ^	d statements. The			
		gation did not indicate the			
	I .	_			
	environment was checked, did not have a conclusion, and/or indicate any additional				
		_			
	recommendation	ns for corrective actions.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447			LDING	NSTRUCTION 00	(X3) DATE COMPL 01/21/	ETED	
	ROVIDER OR SUPPLIER		1	STREET A	NOLLTON RD		
VOCA CO	ORPORATION OF I	NDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	indicated the Qu Disabilities Profe	/12/14 investigation alified Intellectual essional (QIDP) cility's investigation.					
	(individual suppousing the toilet. to rinse a washel the commode and in a 1/2 (one half called 911 and E Services) transpouse [name of hospital treatment via amonom) personnel injury and release staff with wound [Client C] is rest and staff will per (neurological) chaprotocol. [Client and a Comprehe in place, the risk staff to provide hassistance while the toilet. Prelin staff followed the The team is none circumstances of	was assisting [client C] orted by ResCare) with Staff turned to the side oth and [client C] fell off d hit her head resulting f inch) laceration. Staff MS (Emergency Medical orted [client C] to the all for evaluation and abulance. ER (emergency closed and dressed the ed [client C] to ResCare a care instructions. aing comfortably at home afform neuro an ecks for 24 hours per at C] has a history of falls ansive High Risk Plan is a plan for falls directs are with stand-by transferring to and from aninary inquiry suggests are protocols in the plan. atheless investigating the afform the incident to assure appropriate supports"					
	_	/15/14 IAR indicated ing [client C] with					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE : COMPL 01/21/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228					
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE.	(X5) COMPLETION DATE	
	morning hygiene toilet. While sta [client C] leaned toopled (sic) ove noticed blood for of her face" To had "about a forehead" The filled out by staff. The facility's 12/indicated staff #4 time of the incid 12/15/14 investig was interviewed witness statement do not know. On came out of the of the blood. I came of saw [client C] had fee blood. I came of saw [client C] ly instructed [staff [Staff #9] came I staff #9] just let (ambulance) con The facility's 12/indicated client C 12/15/14. Client indicated the client con to the control of the contr	and had her seated on ff was at face basin over and immediately r on to the floor. Staff rming under the left side the IAR indicated client half inch cut on a 12/15/14 IAR was f #9. 15/14 investigation was also working at the tent. The facility's gation indicated staff #4 on 12/15/14. Staff #4's at indicated "I (staff #4) ally thing I know when I other bathroom, [staff on the door and told me to the bathroom and ting on her left side. So I #9] to call the nurse oack and told me nurse and she did. I said to her lay until Amb.						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G447	B. WIN			01/21/	2015
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					NOLLTON RD		
VOCA CO	ORPORATION OF I	NDIANA		INDIAN.	APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		who was with her.					
	Client H's 12/15/14 witness statement						
	indicated client H did not see when the						
		d. Client H's witness					
		ted "I didn't see I just					
		ng [staff #9] and [staff					
		eard [staff #9] ask [staff					
	#4] to help her.	I was in my room getting					
	dressed."						
	An attached 12/15/14 Progress Note						
	indicated "[Clien	nt C] had Nasty fall in the					
	bathroom this Al	M, while being assist					
		mber. Slid down off					
	l ' ' -	s trying to wash her.					
		rward and hit her head.					
		l and she stated to call					
	emerg. (emergen	ncy). She was then taken					
		al) for observation." The					
		gation indicated "IDT					
	(interdisciplinary						
	` 1	ferent ways to help					
		lls such as seat belt for					
	1 ^	ped alarm to alert staff					
		ng out of bed or chair					
	without assistance	· ·					
		from ER physician to					
		(Physical Therapy) apt.					
	(appointment)."						
		icated the facility					
		ude an interview with					
	•						
		iny other staff who had					
		client to determine if					
	starr monitored of	client C while she was in					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447			LDING	NSTRUCTION 00	(X3) DATE COMPL 01/21/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	did not question was placed on the why client C was sitting on the toil investigation did staff was specific C fell off the toil investigation neg place corrective client C from postathroom and/or 12/15/14 investigation neglected levels to ensure a could meet the negligible facility in the QIDP complement C's record 1/14/15 at 1:16 If Record Of Visit was seen at a local The ROV indical "Forehead lacera (cat scan) and ce wound dry for 24 usual. Watch for Recommend PT fall prevention."	he facility's investigation and/or ask how client C e toilet, and/or indicate is being washed while let. The facility's anot indicate where each cally located when client let. The facility's glected to address/put in measures to protect tential falls in the injuries. The facility's gation indicated the dito look at their staffing line staff, who work, eeds of the clients. The 4 investigation indicated eted the investigation. It was reviewed on PM. Client C's 12/15/14 (ROV) indicated client C had a lation. Normal head CT lervical spine CT. Keep 4 hours then wash as a rigns of infection. for strengthening and						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 01/21 /	ETED	
	PROVIDER OR SUPPLIER		p. wiit	STREET A	ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD APOLIS, IN 46228	•	
(X4) ID PREFIX	SUMMARY S	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	ATE	(X5) COMPLETION
7 7	bruising & (and) contusion/Abrass instructions. Tyle Client C's 12/15/the facility's nurshome to assess c from the ER. The the nurse had was transfer the client the bed and from commode using assist with the traindicated "Compiece of gauze conforce from fatransparent mediated that while in the used a glue-like wound together. The ER doctor has the area until the the wound was a inch in lengthConduring the IDT in discovered that is in her wheelchai	Abrasion. Forehead ion. Head Injury lenol for pain." 14 nurse note indicated se went to the group lient C after she returned to the disciplination of the nurse note indicated the disciplination of the wheelchair to the agait belt and pivot to ansfer. The nurse note sumer had a folded up overing the wound on ll, secured with cal tape. Staff reported ER, the doctor there substance to close the Staff also reported that d advised not to cleanse next day. The size of pprox. (approximately) 1 Consumer was present neeting, and it was he 'scoots' herself around r, but she leans forward				NTE	
	notes and/or reco neglected to indi evaluation had b	s." Client C's nurse ord indicated the facility cate when and/or if a PT een set up/scheduled.					
		4 Health Supports ated client C has an					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447		LDING	NSTRUCTION 00	(X3) DATE COMPL 01/21/	ETED	
	PROVIDER OR SUPPLIER		 4114 KN	NOLLTON RD APOLIS, IN 46228	•	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	"In the past, [c injuries as a resu [client C] curren wheelchairEve utilizes a wheelchair to require promp and requires assifrom her wheelch to have a PT eva Client C's 5/13/1 Plan (ISP) indicated does not utilize pambulating her whose prompting her of several redirection belt is fasten (sic continue this goal wheelchair in an [Client C] is still in asking for assifthat require her the wheelchairIn the been noted as fall move out of her Client C's undated High Risk Health used a wheelchair indicated hands-on assistate exiting the van.	hair, she still continues ting to use it properly stance to move into seats hairShe will continue luation annually" 4 Individual Support ted "3.) [Client C] proper precautions when wheelchair, despite staff therwise. She needs ons to make sure her seat e), the team agreed to all (to utilize her appropriate manner). 4.) having slight problems istance in doing things to get out of her the past, [client C] has ling when trying to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G447		(X2) MULTIPLE (A. BUILDING B. WING	00	(X3) DATE COMPI — 01/21		
	PROVIDER OR SUPPLIER		STREET 4114 I	TADDRESS, CITY, STATE, ZIP C KNOLLTON RD NAPOLIS, IN 46228	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	at least standby a	ng/toileting. 7. Should				
	ResCare's undate PREVENTION I client's record. To indicated "POLIO people who are was uncoordinated, pure disoriented. The fall risk assessmential individuals requirement falls. The	indicated client C had ed policy titled FALL PROTOCOL in the The undated policy CY: Falls occur among weak, fatigued, aralyzed, confused or data obtained from the ent will identify which re special measures to be risk for falls can be ral factors as outlined				
	PROCEDURE: 1. Staff should of environment.	orient the person to the				
	2. Staff should protoners a					
	3. Adequate ligh	ating in the environment.				
	4. Close supervi	sion, when applicable.				
	5. Place beds in position as defin	lowest appropriate ed by the IDT.				

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G447	B. WIN			01/21/	2015
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
VOCA C	ORPORATION OF	ΙΝΙΣΙΑΝΙΑ			NOLLTON RD APOLIS, IN 46228		
				l	AI OLIO, IIV 40220		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		,		-			
	6. Side rails up	if applicable.					
	7. Provide ambulatory aids, when						
	applicable.						
	8. Assess medications administered that						
	increase risk of falling.						
	9. Should fall occur staff will notify nurse immediately13. IDT will meet to discuss						
	individualized fa	all prevention per					
	ISP/BSP (Behav	rior Support Plan) or					
	other safety prot	ocols, when applicable."					
	Client C's record	l indicated the following					
		tes (not all inclusive):					
		•					
	-11/6/14 Client (C's IDT met to follow up					
	on falls and ER	visit. The IDT note					
		6/14 "[Client C] fell					
	out (sic) the bed	getting out without					
	asking for assist	ance. The team decided					
	_	chair away from her bed					
	so she can call for	or help. Staff also have					
	to redirect her housemate not to try to						
	help without stat	ff assistance"					
	_	ient C] fell in the					
	bathroom trying						
		Staff will push [client C]					
	to the bathroom	as soon as she gets off					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/21/2015
NAME OF PROVIDER OR SUPPLIER	NIDIANA	STREET A 4114 KI	ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD	1
VOCA CORPORATION OF IN	NDIANA	INDIAN	APOLIS, IN 46228	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION DATE
the van and assist falls."	t her to prevent future			
scratch on her head staff when they we [Client C] said shounable to get hers investigation is be determine what he -12/15/14- [Client while completing Living skills). Stowash out the face some how lost bat toilet. Staff assist floor. [Client C] forehead. She was she was treated an prevention method belt for her wheel discussed [client of secured around he when she is on the falling. [Client C] from a bed and che when she is trying with assistance (staggestions required this plan is remanagement communication.	at C] fell off the toilet and the ADL's (Adult Daily aff said she turned to a towel and [client C] alance and fell off the ted [client C] off the had a gash on her as taken to ER where and released. As a bod [client C] needs a seat alchair. The team also C] having her gait belt are and the safety bars are toilet to prevent her by would also benefit thair alarm to alert staffing to get out the chair sic). If any of these are HRC (Human Rights aval it will be obtained reviewed by the amittee." Client C's IDT meeting notes, ISP			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447		A. BUILDING B. WING			COMPLETED 01/21/2015		
	PROVIDER OR SUPPLIER		D. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD APOLIS, IN 46228		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E.	(X5) COMPLETION DATE
TAG	neglected to deve in regard to client above mentioned also indicated the specifically indictive were to monitor/sin the bathroom and/or injuries. Confidential interplated indicated staff which with client C who bathroom. Confidential interplated "She can't When asked how work in the morn interview A stated part." Confidential interplated how client supervised/monitory when it is the specific part. We come of when ready. We help her up and he confidential interplated to the composition of the client C fellower of the client C fellower when swell often client C fellower mentioned as well of the client C fellower mentioned as well as we	elop a specific risk plan t C's falls. Client C's IDT notes and/or record e facility neglected to eate how facility staff supervise client C while to prevent potential falls rview A stated client C past, but had "no falls ntial interview A ere to be in the bathroom en she was in the dential interview A stand on her own." many staff normally ning, confidential d "Two for the most		IAU			DATE

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G447	B. WIN	G		01/21/	2015
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
VOCAC	ORPORATION OF	ΙΝΙΣΙΑΝΙΑ			NOLLTON RD APOLIS, IN 46228		
	,		T		APOLIS, IN 40226		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
	<u> </u>	hair unlocked and fall.					
We hear hollering and find her on floor."							
	, ve near noner	ing und ima ner on moor.					
	Interview with s	staff #4 on 1/14/15 at 7:35				ļ	
	AM indicated c	lient C fell last month.				ļ	
	Staff #4 stated a	a staff was giving the				ļ	
	client a "sponge	off. Turned to rinse				ļ	
	wash cloth off.	She (client C) fell on				ļ	
	floor." When as	sked if client C had fallen					
	on the floor bef	ore, staff #4 stated "Quite				ļ	
	a few times, but	not fallen on my shift."					
	Interview with	Clinical Supervisor (CS)					
	#1, the QIDP ar	nd LPN #1 on 1/14/15 at				ļ	
	3:35 PM indicat	ted client C was a fall				ļ	
	risk. The CS in	dicated 2 staff (staff #4				ļ	
	and staff #9) we	ere working on 12/15/14				ļ	
	when client C for	ell off the toilet. CS #1				ļ	
	-	ndicated staff #9 was in				ļ	
		hen client C fell off the				ļ	
	-	P indicated she did not					
	•	s to why client C was					
	_	ff on the toilet. The QIDP					
		eated there were no					
		interviews/conducted.					
		QIDP indicated the facility					
		witness statement from					
		indicated staff #9 filled					
		report and the facility					
		her witness statement.					
		w the client fell off the					
		stated "She leaned					
		I." The QIDP and CS #1					
	indicated the fac	cility's investigation did				ļ	

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G447	B. WIN	G		01/21	ZU15
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
\/OC^ \	ORPORATION OF	ΙΝΙΣΙΑΝΙΑ			NOLLTON RD APOLIS, IN 46228		
	ı				AF OLIO, IIN 40220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		client C was placed/sat		TAG			DATE
		staff to ensure the client					
	1	iced on the toilet. CS #1					
		ity staff normally worked					
		•					
	1	CS #1 and the QIDP					
		4 was 1 of the 2 staff					
		the morning shift. CS #1					
		ility neglected to look at					
	_	the group home to					
		ty staff, who worked in					
the home, could meet the needs of the							
clients. The QIDP indicated client C's							
		riewed the falls and made					
		s. LPN #1 and the QIDP					
		C was to see the PT on					
	1/15/15. The QI						
		Γ's recommendations to					
	obtain a seat bel	t and wheelchair/bed					
	alarms had not b	een purchased as they					
	were waiting on	the PT evaluation to be					
	completed. The	QIDP and LPN #1					
	indicated facility	staff were to stay in the					
	bathroom with c	lient C when she was					
	bathing and bein	g toileted to prevent the					
	client from fallir	ng. The QIDP and CS #1					
	indicated the fac	ility did not conduct any					
	additional interv	iews in regard to client					
	C's injury of unk	nown source of					
	12/12/14. QIDP	#1 indicated client C					
	-	e fell. The QIDP and CS					
	#1 indicated only	-					
	· ·	they did not know how					
		I the injury to the client's					
		indicated facility staff					
	<u> </u>						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G447	B. WIN	G		01/21/2015
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUFFLIER			4114 KN	NOLLTON RD	
VOCA CO	ORPORATION OF I	NDIANA		INDIAN	APOLIS, IN 46228	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		C did not fall. When				
asked if client C's fall risk plan had been						
		ated "No." The QIDP				
	and LPN #1 indi	cated client C's mobility				
	risk plan and/or	record did not indicate				
	how facility staff	f were to monitor client				
	C when in the ba	throom to prevent				
	potential falls an	d/or injuries.				
	2. The facility failed to conduct thorough					
	investigations in regard to allegations of					
		and/or injuries of				
	^	for clients B, C and H.				
	Please see W154	•				
	Ticase see Wish	•				
	3. The facility fa	ailed to put in place				
	corrective measu	res to prevent client C				
	from falling in th	ne bathroom. Please see				
	W157.					
		icy and procedures were				
		4/15 at 11:02 AM. The				
	1	1 policy entitled Abuse,				
		ploitation indicated				
	_	vely advocate for the				
	-	of all individuals. All				
	allegations or oc	currences of abuse,				
	neglect, exploita	tion, or mistreatment				
	shall be reported	to the appropriate				
	authorities throu	gh the appropriate				
	supervisory char					
	thoroughly investigated under the					
		t, Rescare, and local,				
		guidelines." The				
	1	-	1			ĺ

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G447	B. WING		01/21/2015
NAME OF P	ROVIDER OR SUPPLIER	-	STREET.	ADDRESS, CITY, STATE, ZIP CODE	
				NOLLTON RD	
VOCA CO	DRPORATION OF I	INDIANA	INDIAN	IAPOLIS, IN 46228	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		defined neglect as			
	"Failure to provide goods and/or				
	services necessary for the individual to				
	avoid physical ha	arm. Failure to provide			
	the support neces	ssary to an individual's			
	psychological an	d social well being.			
	Failure to meet the	he basic need			
	requirements suc	ch as food, shelter,			
	clothing and to p				
		The facility's 2/26/11			
	policy also indicated the facility's				
		ould indicate/include			
	•	rective actions) to			
	prevent future in	*			
	prevent ruture in	erdents.			
	This federal tag i	relates to complaint			
	#IN00162396.	relates to complaint			
	#11 100102 570.				
	9-3-2(a)				
)-3-2(a)				
W000154	483.420(d)(3)				
	STAFF TREATME				
	•	ave evidence that all			
	alleged violations a investigated.	are thoroughly			
	-	ation, interview and	W000154	CORRECTION: The facility	02/20/2015
		r 4 of 5 allegations of	W 000134	must have evidence that all	02/20/2013
		nd/or injuries of unknown		alleged violations are thorough	ıly
		the facility failed to		1 3	he l
	<i>'</i>	•		facility has located the	
	•	h investigations in regard		investigation into Client H's discovered injury on 11/5/14.	
	•	possible neglect and/or		The Residential Manager	
	3	own source for clients B,		responsible for failing to complet	e
	C and H.			thorough investigations of Client	
				C's falls has been removed from	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING X3) DATE SURVE COMPLETED 01/21/2015			ETED		
NAME OF I	DDOVIDED OD CLIDDI IEE		B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIEF				NOLLTON RD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	· ·		DATE
	Findings include); -			the facility and no longer serves in a formal supervisory capacity.		
	1 D	12/15 -1			ADDENDUM 2/17/15: The		
	1. During the 1/13/15 observation period between 5:04 PM and 6:45 PM and the				Operations Team, including		
					the Program Manager and		
		tion period between 6:14			QIDP, will directly oversee a	II	
		M, at the group home,			investigations. The		
	client C utilized				Residential Manager will receive additional training		
		lient C did not wear a			toward assisting with		
		the wheelchair. Client C			gathering evidence, includin	g	
		around the client's waist.			conducting thorough witness	S	
	Specifically during the 1/13/15				interviews. The Clinical		
	_	od, client C sat forward			Supervisor and Program		
		heelchair seat. Client C			Manager will assure that conclusions are developed		
	I	irected to sit/scoot back			that match the collected		
		r and to sit up straight.			evidence. The governing Boo	ly	
	~	15 observation period,			will assume complete		
	upon arrival, the	re were 2 direct care staff			responsibility for		
	(staff #4 and #6)	and the group home			investigating any discovered		
	manager (staff#	1) at the group home.			injuries that require outside medical treatment. When an		
	Staff #6 was ass	isting clients to get up			evidence of staff negligence	y	
	and get dressed	and staff #1 was assisting			is uncovered or alleged the		
	client #8 to prep	are breakfast. Staff #4			Operations Team will take		
		cation room passing the			control of all aspects of the		
	-	tions. Staff #4 stayed in			investigation process.		
	the medication r	oom the entire					
	observation peri	od except to come out of					
	the medication r	oom to get clients for her			PREVENTION:		
	morning medica	tions. Staff #4 did not					
	assist with the bi	reakfast meal when			ADDENDUM 2/17/15: A tracking spreadsheet for		
	clients were not	getting medications.			incidents requiring		
	Staff #4 wore a i	nasal oxygen tube while			investigation, follow-up and		
	carrying a portal	ole oxygen container with			corrective/protective		
	her. During the	1/14/15 above			measures will be maintained	I	
	observation peri-	od, client C required			and distributed daily to		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	LDING	00	COMPLETED	
		15G447	A. BUI B. WIN			01/21/2015	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			NOLLTON RD		
VOCAC	ORPORATION OF	INDIANA			APOLIS, IN 46228		
VOCAC	URPORATION OF	INDIANA		INDIAN	AFOLIS, IN 40228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	stand by and/or	physical assistance when			facility supervisors and the		
	transferring fron	n her wheelchair to the			Operations Team. The Clinica	al e	
	couch. Staff #1	physically assisted client			Supervisor (Administrative		
		grabbing the client's gait			level management) will mee	t	
		e client during the			with his/her facility		
	-				management teams weekly		
	transfer. Client	•			to review the progress made		
		walking as the client was			on all investigations that are open for their homes.		
	blind. Client E	required staff physical			Residential Managers will be		
	assistance as we	ll when ambulating as the			required to attend and sign		
	client used a wa	lker and wore a gait belt			an in-service at these		
	for transfers. Cl	ient B required staff			meetings stating that they		
		monitoring due to the			are aware of which		
		of trying to get into the			investigations with which		
					they are required to assist, a	s	
	kitchen to drink	tea (corree).			well as the specific		
					components of the		
		portable incident reports,			investigation for which they		
		ernal Incident/Accident			are responsible, within the		
	Reports (IARs)	and/or investigations			five business day timeframe.		
	were reviewed o	on 1/14/15 at 11:17 AM.			The Clinical Supervisor will		
	The facility's ren	portable incident reports,			review each investigation to		
		estigations indicated the			ensure that they are		
	following (not a	•			thorough —meeting regulatory and operational		
	Ionowing (not a	ii iiiciusive).			standards, and will not		
	10/10/14 !! 4 . T	(, 00 5) 1			designate an investigation, a	ne	
		(staff #5) brushed [client			completed, if it does not mee		
	_	as complaining of pain on			these criteria. The Program	"	
	her head where	I brushed. I asked her			Manager will also conduct		
	what was wrong	(sic) she stated that she			spot checks of investigations	5,	
	fell as she got up	o off the toilet and hit her			focusing on serious incidents		
		et seat." The IAR			that could potentially have		
		ere is a scratch that is a			occurred as a result of staff		
		t is red and sore to the			negligence. The Clinical		
	` ′	is icu anu sore to the			Supervisors will provide		
	touch (sic)."				weekly updates to the		
					Program Manager on the		
	The facility's 12	/31/14 follow-up report			status of investigations.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		15G447	B. WIN			01/21/2015
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				NOLLTON RD	
VOCA CO	ORPORATION OF I	NDIANA			APOLIS, IN 46228	
					7.1 OLIO, IIV 10220	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG		DATE
		eportable incident report			Failure to complete thorough	1
	indicated "In d	oing the investigation it			investigations within the	
	was reported from	m the staff that worked			allowable five business day	
	that evening [clie	ent C] was assisted to the			timeframe will result in	
		er bed with no injuries			progressive corrective action to all applicable team	'
		rening. [Client C]			members.	
	_	at she had fell (sic) and			RESPONSIBLE PARTIES:	
					QIDP, Residential Manager,	
		iber when she fell. Staff			Team Leader, Direct Support	
	_	ed on [client C's] high			Staff, Operations Team	
	risk plan for falls	s and will monitor [client				
	C] more closely.	"				
	The facility's 12/	12/14 attached witness				
		tigation in regard to the				
		vn source indicated only				
		f were interviewed in				
	_	C's injuries. The staffs'				
	witness statemen	its indicated the				
	following:					
	-Staff #7 was int	erviewed on 12/12/14.				
	Staff #7's witnes	s statement indicated				
		all at least I don't think				
		take her and usually she				
		she fell. She would like				
	(sic) 'I fall, I fall'	•				
	-Staff #8 was int	erviewed on 12/12/14.				
	Staff #8's witnes	s statement indicated				
	"She didn't fall.	I assisted her to the				
		sted on the toilet and off				
		she didn't fall cause if				
		d of (sic) needed to assist				
	her up together."					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447		A. BUII	LDING	00	COMPL 01/21/	ETED	
		130447	B. WIN			01/21/	2010
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD		
VOCA CO	ORPORATION OF I	NDIANA			APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	The feether 10/	12/14 investigation					
	indicated the faci	· ·					
		ients who lived in the					
		e facility's investigation					
		H was interviewed on					
		PM. Client H's witness					
		ted "I didn't actually see					
		ent C] on the toilet. I					
		her [staff #7] bring					
		bathroom and put her on					
		d her not to move and					
		on her own and fell. I					
	_	room and heard [client					
		see anything. I was in					
	the living room."	-					
	investigation did	-					
		y-up interviews and/or					
	•	onducted in regard to					
		I statements. The					
		ation did not indicate the					
		s checked, did not have a					
	•	or indicate any additional					
		s for corrective actions.					
		12/14 investigation					
	-	alified Intellectual					
	Disabilities Profe	/					
	conducted the fac	cility's investigation.					
		was assisting [client C]					
		orted by ResCare) with					
	_	Staff turned to the side					
		oth and [client C] fell off					
	the commode and	d hit her head resulting					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	COMPL		
AND FLAN	OF CORRECTION	15G447	A. BUI	LDING	00	01/21/	
		130447	B. WIN			01/21/	2013
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VOCA C	ORPORATION OF	NDIANA			NOLLTON RD APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	`	f inch) laceration. Staff					
		MS (Emergency Medical					
		orted [client C] to the					
	[name of hospita	l] for evaluation and					
	treatment via am	bulance. ER (emergency					
	room) personnel	closed and dressed the					
	injury and releas	ed [client C] to ResCare					
	staff with wound	care instructions.					
	[Client C] is rest	ing comfortably at home					
	and staff will per	rform neuro					
	(neurological) ch	necks for 24 hours per					
	protocol. [Clien	t C] has a history of falls					
	and a Comprehe	nsive High Risk Plan is					
		plan for falls directs					
	-	ner with stand-by					
	-	transferring to and from					
		ninary inquiry suggests					
		e protocols in the plan.					
		etheless investigating the					
		f the incident to assure					
		propriate supports"					
	suii provided up	propriate supports					
	The facility's 12/	15/14 IAR indicated					
	1	ing [client C] with					
		e and had her seated on					
	1	ff was at face basin					
		over and immediately					
		er on to the floor. Staff					
		rming under the left side The IAR indicated client					
	C had "about a						
		e 12/15/14 IAR was					
	filled out by staf	f #9.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE COMPL		
11112 12111	or confidence.	15G447		LDING		01/21/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				NOLLTON RD		
VOCA C	ORPORATION OF I	NDIANA			APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		/15/14 investigation		TAG	Dia teliate 1 y		DATE
		4 was also working at the					
		ent. The facility's					
		gation indicated staff #4					
		on 12/15/14. Staff #4's					
		at indicated "I (staff #4)					
		nly thing I know when I					
		other bathroom, [staff					
		on the door and told me					
	=	Il (sic) and it is so much					
		ut of the bathroom and					
	saw [client C] ly	ing on her left side. So I					
	instructed [staff]	#9] to call the nurse.					
	[Staff #9] came 1	back and told me nurse					
	said to call 911 a	and she did. I said to					
	[staff #9] just let	her lay until Amb.					
	(ambulance) con	nes."					
	The facility's 12	/15/14 investigation					
		/15/14 investigation C was interviewed on					
		t C's witness statement					
		ent fell in the bathroom at					
		ouse. The witness					
		ted client C could not					
		who was with her.					
	1	14 witness statement					
		H did not see when the					
		d. Client H's witness					
		ted "I didn't see I just					
		ng [staff #9] and [staff					
		eard [staff #9] ask [staff					
		I was in my room getting					
	dressed."						

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Togat7 Samus Street Address City, State, 200 O1/21/2015	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA O(4) ID SUMMARY STATEMENT OF DEFICIENCIES PRETIX (FACI IDEFCIENCY MUST BE PRECEDED BY PULL TAG REGULATORY OR LEC IDENTIFYING HEROBIMATION) An attached 12/15/14 Progress Note indicated "[Client C] had being assist (sic) by staff member. Slid down off toilet as staff was trying to wash her. [Client C] fell forward and hit her head. Nurse was called and she stated to call emerg (emergency). She was then taken to Hosp. (hospital) for observation." The facility's investigation indicated "IDT (interdisciplinary team) met and discussed the different ways to help prevent future falls such as sea belt for wheelchair and bed alarm to alert staff when she is getting out of bed or chair without assistance. Also a recommendation from ER physician to schedule for PT (Physical Therapy) apt. (appointment)." The facility's investigation indicated the facility failed to include an interview with staff #9, and/or any other staff who had worked with the client to determine if staff monitored client C while she was in the bathroom. The facility's investigation did not question and/or ask how client C was placed on the toilet, and/or indicate why client C was being washed while sitting on the toilet. The facility's investigation did not indicate where each staff was specifically located when client D fell off the toilet. The facility's investigation did not indicate where each staff was specifically located when client D fell off the toilet. The facility is investigation indicated the facility failed	ANDILAN	or conduction			ING	00		
ANALO PROPUBLY OR SUPPLIES VOCA CORPORATION OF INDIANA VOCA CORPORATION OF INDIANA SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG An attached 12/15/14 Progress Note indicated "[Client C] had Nasty fall in the bathroom this AM, while being assist (sic) by staff member. Slid down off toilet as staff was trying to wash her. [Client C] fell forward and hit her head. Nurse was called and she stated to call emerg. (emergency). She was then taken to Hosp. (hospital) for observation." The facility's investigation indicated "IDT" (interdisciplinary team) met and discussed the different ways to help prevent future falls such as seat belt for wheelchair and bed alarm to alert staff when she is getting out of bed or chair without assistance. Also a recommendation from ER physician to schedule for PT (Physical Therapy) apt. (appointment)." The facility's investigation indicated the facility failed to include an interview with staff #9, and/or any other staff who had worked with the client to determine if staff monitored client C while she was in the bathroom. The facility's investigation did not question and/or ask how client C was placed on the toilet, and/or indicate why client C was being washed while sitting on the toilet. The facility's investigation did not indicate where each staff was specifically located when client D fell off the toilet. The facility's investigation indicated the facility failed investigation indicated the facility failed in the client. The facility's investigation indicated the facility failed investigation indicated th			100117		CTD FET A	DDDEGG GITY GTATE ZID GODE	01/21/	2010
INDIANAPOLIS, IN 46228 ID SUMMARY STATEMENT OF DETICIENCIES TAG REGULATORY OR LIST IDENTIFYING INFORMATION) TAG REGULATORY OR LIST IDENTIFYING INFORMATION TAG REGULATORY OR LIST IDENTIFY OR LIST IDENTIFY OR LIST IDENTIFY OR LIST IDENTIF	NAME OF F	PROVIDER OR SUPPLIER	₹					
PRETX TAG REGULATORY OR LISC IDENTIFYING INFORMATION) An attached 12/15/14 Progress Note indicated "[Client C] had Nasty fall in the bathroom this AM, while being assist (sic) by staff member. Slid down off toilet as staff was trying to wash her. [Client C] fell forward and hit her head. Nurse was called and she stated to call emerg. (emergency). She was then taken to Hosp. (hospital) for observation." The facility's investigation indicated "IDT (interdisciplinary team) met and discussed the different ways to help prevent future falls such as seat belt for wheelchair and bed alarm to alert staff when she is getting out of bed or chair without assistance. Also a recommendation from ER physician to schedule for PT (Physical Therapy) apt. (appointment)." The facility's investigation indicated the facility failed to include an interview with staff #9, and/or any other staff who had worked with the client to determine if staff monitored client C while she was in the bathroom. The facility's investigation did not question and/or ask how client C was placed on the toilet. The facility's investigation did not indicate where each staff was specifically located when client D fell off the toilet. The facility's investigation did not indicated whe client D fell off the toilet. The facility's investigation indicated the facility failed	VOCA C	ORPORATION OF	INDIANA					
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An attached 12/15/14 Progress Note indicated "[Client C] had Nasty fall in the bathroom this AM, while being assist (sic) by staff member. Slid down off toilet as staff was trying to wash her. [Client C] fell forward and hit her head. Nurse was called and she stated to call emerg. (emergency). She was then taken to Hosp. (hospital) for observation." The facility's investigation indicated "IDT" (interdisciplinary team) met and discussed the different ways to help prevent future falls such as seat belt for wheelchair and bed alarm to alert staff" when she is getting out of bed or chair without assistance. Also a recommendation from ER physician to schedule for PT" (Physical Therapy) apt. (appointment)." The facility's investigation indicated the facility failed to include an interview with staff #9, and/or any other staff who had worked with the client to determine if staff monitored client. C while she was in the bathroom. The facility's investigation did not question and/or ask how client C was placed on the toilet, and/or indicate why client C was being washed while sitting on the toilet. The facility's investigation did not indicate where each staff was specifically located when client D fell off the toilet. The facility's 12/15/14 investigation indicated the facility failed		`			I	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	
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on the toilet. The facility's investigation did not indicate where each staff was specifically located when client D fell off the toilet. The facility's 12/15/14 investigation indicated the facility failed		placed on the toi	llet, and/or indicate why					
did not indicate where each staff was specifically located when client D fell off the toilet. The facility's 12/15/14 investigation indicated the facility failed								
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the toilet. The facility's 12/15/14 investigation indicated the facility failed								
investigation indicated the facility failed								
		the toilet. The fa	acility's 12/15/14					
to look at their staffing levels to ensure		investigation ind	licated the facility failed					
		to look at their s	taffing levels to ensure					

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Event ID:

93FG11 Facility ID: 000961

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G447	B. WIN			01/21/	2015
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
VOCA CO	ORPORATION OF	INDIANA			NOLLTON RD APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		,	+	TAG	Dia lettike 1 y		DATE
		orked, could meet the nts. The facility's					
		gation indicated the					
	l '						
	QIDP completed	I the investigation.					
	Client Clarecard	l was reviewed on					
		PM. Client C's 12/15/14					
	_	te indicated on "12/12/14					
		a scratch on her head that					
	1	taff when they were					
		r. [Client C] said she					
		s unable to get herself					
		n investigation is being					
		ermine what happened.					
	-	nt C] fell off the toilet					
		g her ADL's (Adult Daily					
		taff said she turned to					
		e towel and [client C]					
		alance and fell off the					
		sted [client C] off the					
		had a gash on her					
		ras taken to ER where					
	she was treated a	and released"					
		erview A stated client C					
		past, but had "no falls					
	<u> </u>	ntial interview A					
		ere to be in the bathroom					
		en she was in the					
		idential interview A					
		stand on her own."					
	When asked how	w many staff normally					
		ning, confidential					
	interview A state	ed "Two for the most					

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Event ID:

93FG11

Facility ID: 000961

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		15G447	B. WIN			01/21/	2015
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t		1	NOLLTON RD		
VOCA CO	ORPORATION OF	INDIANA			APOLIS, IN 46228		
					711 0210, 114 10220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
	part."						
	Confidential inte	erview B stated when					
	asked how client	t C was to be					
	supervised/moni	tored in the bathroom,					
	_	re. Help on commode.					
	_	down and hold onto gait					
		out and then she calls us					
		e go back in there and					
	I	hold onto gait belt."					
		•					
		erview B indicated client					
		to the safety bar in the					
	bathroom as wel	l. When asked how					
	often client C fel	II, confidential interview					
	B stated "Not that	at much. She will jump					
	up from wheelch	nair unlocked and fall.					
	. ^	g and find her on floor."					
	.,, 0 0	-6					
	Interview with o	taff #4 on 1/14/15 at 7:35					
		ient C fell last month.					
		staff was giving the					
		off. Turned to rinse					
		She (client C) fell on					
		ked if client C had fallen					
	on the floor befo	ore, staff #4 stated "Quite					
	a few times, but	not fallen on my shift."					
		-					
	Interview with C	Clinical Supervisor (CS)					
		d LPN #1 on 1/14/15 at					
	, ,	ed client C was a fall					
		licated 2 staff (staff #4					
	· · · · · · · · · · · · · · · · · · ·	re working on 12/15/14					
		ll off the toilet. CS #1					
	and the QIDP in	dicated staff #9 was in					

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PRINTED: 03/06/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ	ULTIPLE CO LDING	onstruction 00	(X3) DATE COMPL	ETED	
		15G447	B. WIN	G		01/21/	/2015
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD		
VOCA C	ORPORATION OF I	NDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATF	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the bathroom wh	en client C fell off the					
	`	P indicated she did not					
	•	to why client C was					
	_	f on the toilet. The QIDP					
		ated there were no					
	additional staff is	nterviews/conducted.					
	CS #1 and the Q	IDP indicated the facility					
		witness statement from					
	staff #9. CS #1 i	indicated staff #9 filled					
		report and the facility					
		ner witness statement.					
		the client fell off the					
		stated "She leaned					
		" The QIDP and CS #1					
		ility's investigation did					
		client C was placed/sat					
	on the toilet by s	taff to ensure the client					
		ced on the toilet. CS #1					
		ty staff normally worked					
	_	CS #1 and the QIDP					
		4 was 1 of the 2 staff					
		the morning shift. CS #1					
		ility did not look at					
		the group home to					
		y staff, who worked in					
	•	meet the needs of the					
		OP and CS #1 indicated					
	_	ot conduct any additional					
	_	ard to client C's injury of					
		of 12/12/14. QIDP #1					
		C had indicated she fell.					
	-	S #1 indicated only 2					
		iewed and they did not					
	know how client	C received the injury to					

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Event ID:

93FG11

Facility ID: 000961

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPL	ETED
		15G447	A. BUII B. WIN			01/21	/2015
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			NOLLTON RD		
VOCA C	ORPORATION OF	ΙΝΓΙΔΝΙΔ			APOLIS, IN 46228		
					AI OLIS, III 40220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		The QIDP indicated					
	facility staff indi	icated client C did not					
	fall.						
	2. The facility's	reportable incident					
	reports, the facil	-					
	-	nt Reports (IARs) and/or					
		ere reviewed on 1/14/15					
	_						
		he facility's reportable					
	incident reports,						
	_	dicated the following					
	(not all inclusive	e):					
	-11/5/14 "The nu	urse was doing routine					
		he group home. And					
		ned [client H] (An					
		orted By Rescare) she					
		of [client H's] knees had					
		olor to them and the left					
		a 2/3 (two third) size in					
	diameter sore sh	e had been picking					
	atAn investiga	ation is being conducted					
	into the probable	e cause of the injury"					
	The facility did	not provide any					
	documentation of	of an investigation in					
		H's injuries of unknown					
	source.	and market of animotric					
	source.						
	-11/5/14 The min	rse was doing routine					
		he group home. And					
		ned [client B] (An					
		orted by Rescare) she					
		on her right butt cheek a					
	half size in diam	eter (sic). An observed					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/21/2015
	PROVIDER OR SUPPLIES		4114 k	ADDRESS, CITY, STATE, ZIP CODE KNOLLTON RD NAPOLIS, IN 46228	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	27, 2014 that [c] and plopped her and the staff ass staff arrived bac [client B] was conthat time there with the probable cau. The facility's 11 to the 11/5/14 resindicated "In conit was not determ occurred. But it B's] behavior surfacility document follow up report facility document regard to client assource. Interview with CAM indicated the and reportable in 11/1/14 to the preview. CS #1 cadditional document westigations.	was reported on October lient B] had a behavior reself down on the ground isted her up and when the ek to the home. (sic) hecked for bruising and at was no bruisingAn Il be conducted in to (sic) use of the injury" //14/14 follow-up report reportable incident inducting the investigation mined how the injury is addressed in [client pport plan that she will he ground to get attention in The 11/5/14 reportable and/or the 11/14/14 it did not indicate the inted its investigation in B's injury of unknown CS #1 on 1/14/15 at 11:15 he facility's investigations incident reports from resent were provided for did not provide any mentation of			

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Facility ID: 000961

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15G447	A. BUILDING B. WING		01/21/2015
	PROVIDER OR SUPPLIER		4114 K	ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD NAPOLIS, IN 46228	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W000157	9-3-2(a) 483.420(d)(4)				
	STAFF TREATME If the alleged viola corrective action in Based on interviol 1 of 5 allegations injuries of unknow facility failed to measures to previous the bathroom. Findings include The facility's rep IARs and/or inve following (not all -11/11/14 "Upon [client C] (An in Rescare) had just van and into the the staff continue individuals off the wheeled herself without asking so While [client C]	tion is verified, appropriate nust be taken. ew and record review for sof abuse/neglect and/or own source reviewed, the put in place corrective rent client C from falling : cortable incident reports, rnal Incident/Accident and/or investigations in 1/14/15 at 11:17 AM. cortable incident reports, estigations indicated the	W000157	CORRECTION: If the alleged violation is verified, appropriate corrective action must be take Specifically, Client C has beguing receiving twice weekly physical therapy sessions and a daily home exercise program has be initiated to enhance Client C's core strength to diminish the incidence of falls such as occurred on 12/12/14 and 12/15/14. An Occupational Therapy evaluation has been scheduled for Client C to evaluate effectiveness of current adaptive equipment and to obtrecommendations for enhancements. In the interim, after appropriate due process team will provide the following adaptive modifications: the sebelt will be re-fitted to Client C wheelchair and a chair alarm be installed to alert staff when seat belt has become unfasted Client C will receive enhanced supervision—line of sight observation and 15 minute checks while in her bedroom. The team will also provide a modificial to the colercian colercians and audio monitor of the placed in her bedroom. The team will also provide a modificial seat with side rails. The nurse will modify Client C's	te en. un al een uate tain the lat essential the ened. d A will e

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Event ID:

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Facility ID: 000961

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		15G447	B. WIN	IG		01/21/20)15
NAME OF I	PROVIDER OR SUPPLIE	R	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
TVI NIL OF I	ROVIDER OR SOLVER	I.			NOLLTON RD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	causing her to f	all to her knees causing an			Comprehensive High Risk Pla		
	(sic) half inch in	n diameter injury to the			for falls to clarify the expectation for "stand by" assistance while		
	right knee. The	area was cleaned with			Client C is in the bathroom	,	
	peroxide and oi	ntment applied to the area			including but not limited to har	nds	
	1 ^	th bandaide (sic)[Client			on use of a gait belt at all time		
		sk plan for falls in place			while client C is toileting and		
		ontinue to implement her			showering. PREVENTION:		
		*			ADDENDUM 2/17/15: After		
	1 .	er moral support. The			completing investigations in		
		team will be meeting to			which the allegations are		
	determine other	ways to ensure [client			verified, the QIDP, with the		
	C's] safety."				guidance of the Clinical		
					supervisor and Program	_	
	-12/12/14 "As I	(staff #5) brushed [client			Manger, will bring all relevar	it	
		as complaining of pain on			elements of the interdisciplinary team		
	_	I brushed. I asked her			together to develop		
					corrective measures to		
		g (sic) she stated that she			ensure the heal and safety of	f	
	_	p off the toilet and hit her			clients. The Residential	-	
		et seat." The IAR			Manager will develop and		
	indicated "Th	ere is a scratch that is a			maintain a staffing matrix that		
	(sic) inch long i	t is red and sore to the			assures adequate direct support		
	touch (sic)."				staff who possess the training,		
					skills and capabilities to provide		
	The facility's 12	2/31/14 follow-up report			appropriate active treatment and	i l	
	_	reportable incident report			assure the health and safety of		
		nt C's] injury has healed			clients at all times. Members of		
	_	nedical treatment was			the Operations Team and the		
					QIDP will conduct active treatment observations and		
		ig the investigation it was			documentation reviews no less		
	_	ne staff that worked that			than five times weekly for the		
	evening [client	C] was assisted to the			next 21 days, no less than 3		
	bathroom into h	er bed with no injuries			times weekly for an additional 14	₁	
	occurring that evening. [Client C]				Days, and no less than twice		
	however said that she had fell (sic) and				weekly for an additional 60 Days	.	
		nber when she fell. Staff			At the conclusion of this period of		
		ned on [client C's] high			intensive administrative		
	are being redail	ica on [chent C 8] mgn					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G447	B. WIN	IG		01/21/2015	
NAME OF F	PROVIDER OR SUPPLIEF	·	-		ADDRESS, CITY, STATE, ZIP CODE		
					NOLLTON RD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		i
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE	—
		s and will monitor [client			monitoring and support, the Operations Team will determine		
	C] more closely.	."			the level of ongoing support		
		4044			needed at the facility.		
	1	/12/14 investigation			Administrative support at the		
		/12/14 investigation did			home will focus on mentorship		
		usion, and/or indicate			and training of supervisory staff,		
	1 -	ecommendations for			monitoring and coaching of direct support staff, and evaluation of	π	
	corrective action	ns.			the effectiveness of current risk		
					plans and safety protocols.		
		was assisting [client C]			RESPONSIBLE PARTIES	:	
	`	orted by ResCare) with			QIDP, Residential Manager,		
		Staff turned to the side			Team Leader, Health Services Team, Direct Support Staff,	5	
		loth and [client C] fell off			Operations Team		
	the commode an	d hit her head resulting					
	in a 1/2 (one hal	f inch) laceration. Staff					
	called 911 and E	EMS (Emergency Medical					
	Services) transpo	orted [client C] to the					
	[name of hospita	al] for evaluation and					
	treatment via am	abulance. ER (emergency					
	room) personnel	closed and dressed the					
	injury and releas	sed [client C] to ResCare					
	staff with wound	d care instructions.					
	[Client C] is rest	ing comfortably at home					
	and staff will pe	rform neuro					
	(neurological) cl	necks for 24 hours per					
	protocol. [Clien	t C] has a history of falls					
	and a Comprehe	nsive High Risk Plan is					
	in place, the risk	plan for falls directs					
	staff to provide l	her with stand-by					
	assistance while	transferring to and from					
	the toilet"						
	The facility's 12	/15/14 investigation					
	_	interdisciplinary team)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		15G447	B. WIN			01/21/	2015
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF			4114 KN	NOLLTON RD		
	ORPORATION OF				APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
		ed the different ways to					
		are falls such as seat belt					
		nd bed alarm to alert staff					
		ing out of bed or chair					
	without assistan						
		from ER physician to					
		(Physical Therapy) apt.					
	(appointment)."	•					
	investigation inc	licated the facility's					
	investigation fai	led to address/put in					
	place corrective	measures to protect					
	client C from po	tential falls in the					
	bathroom and/or	injuries.					
	Interview with C	Clinical Supervisor (CS)					
	#1, the QIDP an	d LPN #1 on 1/14/15 at					
		ed client C's IDT met and					
	reviewed the fall	ls and made					
	recommendation	ns. LPN #1 and the QIDP					
		C was to see the PT on					
	1/15/15. The QI						
	`	T's recommendations to					
		t and wheelchair/bed					
		een purchased as they					
		client C's PT (physical					
		ion to be completed. The					
		#1 indicated facility staff					
	-	he bathroom with client					
	_	bathing and being					
	_	nt the client from falling.					
	•	PN #1 indicated client					
	_	plan and/or record did					
		facility staff were to					
	monitor client C	when in the bathroom to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G447	B. WIN			01/21/	2015
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				NOLLTON RD		
VOCA CO	ORPORATION OF I	NDIANA			APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	prevent potential	falls and/or injuries.					
	#IN00162396.	relates to complaint					
	9-3-2(a)						
W000240	relevant intervention individual toward Based on intervior 1 of 4 sampled c Individual Support indicate how fact monitor/supervise	gram plan must describe ons to support the independence. ew and record review for lients (C), the client's ort Plan (ISP) failed to ility staff were to se the client, when in the vent falls/injuries.	Woo	00240	CORRECTION: The individual program plan musdescribe relevant interventions to support the individual toward independence. Specifically, the facility nurse will modify Client Comments.	9	02/20/2015
	the facility's inte Reports (IARs) a were reviewed of The facility's rep IARs and/or inve following (not al -11/11/14 "Upon [client C] (An in Rescare) had just van and into the	portable incident reports, rnal Incident/Accident and/or investigations in 1/14/15 at 11:17 AM. portable incident reports, estigations indicated the all inclusive): In arrival to group home dividual Supported by the been assisted off the group home by staff. As ead to assist the other			Comprehensive High Risk Plan for falls to clarify the expectations for "stand by" assistance while Clien C is in the bathroom including but not limited to hands on use of a gait belt at all times while client is toileting and showering. The team will also provide a modified toilet seat with side rails. Additional modifications may be made after Client C's scheduled Occupational Therapy appointment. A review of incident documentation and current risk plans indicated this deficient practice did not affect any	or t ut C	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			(X3) DATE SURVEY	\Box
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		15G447	B. WIN			01/21/2015	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				NOLLTON RD		
VOCA CO	ORPORATION OF	NDIANA			APOLIS, IN 46228		
					, ii olio, iii 10220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	011
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETIC DATE	JN
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	<u> </u>	DATE	
		ne van (sic) [client C]			additional clients.		
	wheeled herself into the bathroom without asking someone to assist her.						
		was in the bathroom she			PREVENTION:		
	proceeded to tak	e off her brief and pants					
	causing her to fa	ll to her knees causing an			The QIDP will assure that the		
	(sic) half inch in	diameter injury to the			nursing team is included in all		
	right knee. The	area was cleaned with			discussions/decisions relevant to clients' health and safety and		
	peroxide and oin	tment applied to the area			modifications will be made to		
	and covered with	n bandaide (sic)[Client			Comprehensive High Risk Plans		
		k plan for falls in place			accordingly. The nurse manager		
		ntinue to implement her			will review all reports of		
		r moral support. The			significant health and safety		
	ı ^	team will be meeting to			issues and will meet with the		
		ways to ensure [client			Operations Team weekly to		
		ways to ensure [chefit			discuss health and safety issues		
	C's] safety."				including but not limited to needed updates to risk plans. The		
	10/10/14 !! 4	(, (0) () () ()			nurse manager will review all	.0	
		(staff #5) brushed [client			facility risk plan modifications for	,	
	_	s complaining of pain on			the next 90 days to assure they		
		brushed. I asked her			contain appropriate detail, and		
		(sic) she stated that she			will conduct periodic audits of		
		off the toilet and hit her			facility risk plans on an ongoing		
	head on the toile	t seat." The IAR			basis.		
	indicated "The	re is a scratch that is a					
	(sic) inch long it	is red and sore to the					
	touch (sic)."				RESPONSIBLE PARTIES:		
	The facility's 12	31/14 follow-up report			QIDP, Residential Manager, Tea	n	
	1	eportable incident report			Leader, Health Services Team,		
		nt C's] injury has healed			Direct Support Staff, Operations		
	-	edical treatment was			Team		
		g the investigation it was					
	l '	•					
	_	e staff that worked that					
	evening [client C	c] was assisted to the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G447	B. WIN	G		01/21/2015	
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	ROVIDER OR SOLI EIER				NOLLTON RD		
VOCA CO	ORPORATION OF	NDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
		er bed with no injuries					
	_	rening. [Client C]					
		at she had fell (sic) and					
		ber when she fell. Staff					
	_	ed on [client C's] high					
	-	s and will monitor [client					
	C] more closely.	"					
	-12/15/14 "Staff	was assisting [client C]					
		orted by ResCare) with					
		Staff turned to the side					
	_	oth and [client C] fell off					
		d hit her head resulting					
		f inch) laceration. Staff					
	`	, , , , , , , , , , , , , , , , , , ,					
		MS (Emergency Medical					
	, ·	orted [client C] to the					
		l] for evaluation and					
		bulance. ER (emergency					
		closed and dressed the					
		ed [client C] to ResCare					
		care instructions.					
		ing comfortably at home					
	and staff will per						
	` ' '	necks for 24 hours per					
		t C] has a history of falls					
	•	nsive High Risk Plan is					
	-	plan for falls directs					
	•	ner with stand-by					
		transferring to and from					
	the toilet"						
	Client C's record	was reviewed on					
		PM. Client C's 5/13/14					
		Addendum indicated					
	Licuini Supports	1 Iddonadiii iiidloutou				I	

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/21/2015			
	PROVIDER OR SUPPLIER CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION			
	client C has an unsteady gait. The addendum indicated "In the past, [client C] has had several injuries as a result of falls; therefore [client C] currently utilizes a wheelchairEven though [client C] utilizes a wheelchair, she still continues to require prompting to use it properly and requires assistance to move into seats from her wheelchair" Client C's 5/13/14 Individual Support Plan (ISP) indicated "3.) [Client C] does not utilize proper precautions when ambulating her wheelchair, despite staff prompting her otherwise. She needs several redirections to make sure her seat belt is fasten (sic), the team agreed to continue this goal (to utilize her wheelchair in an appropriate manner). 4.) [Client C] is still having slight problems in asking for assistance in doing things that require her to get out of her wheelchairIn the past, [client C] has been noted as falling when trying to move out of her wheelchair." Client C's undated Decreased Mobility High Risk Health Plan indicated client C used a wheelchair for all mobility. The risk plan indicated "4. Staff to provide hands-on assistance when entering and exiting the van. 5. Staff to provide standby assistance during in home ambulation exercises. 6. Staff to provide						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 01/21	LETED
	PROVIDER OR SUPPLIER		4114 k	ADDRESS, CITY, STATE, ZIP CODE KNOLLTON RD NAPOLIS, IN 46228		
				1AFOLIS, IN 40220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	at least standby a showering/bathin	assistance during ng/toileting"				
	ResCare's undate PREVENTION client's record. indicated "POLI people who are uncoordinated, presented. The fall risk assessment individuals requirement falls. The prevent falls.	I indicated client C had ed policy titled FALL PROTOCOL in the The undated policy CY: Falls occur among weak, fatigued, paralyzed, confused or e data obtained from the ent will identify which ire special measures to be risk for falls can be tral factors as outlined				
	PROCEDURE:					
	Staff should of environment.	orient the person to the				
	2. Staff should proton footwear, mats a					
	3. Adequate ligh	nting in the environment.				
	4. Close supervi	ision, when applicable.				
	5. Place beds in position as defin	lowest appropriate ed by the IDT.				
	6. Side rails up	if applicable.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SI	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G447	B. WIN			01/21/2	2015
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VOCA C		NIDIANIA			NOLLTON RD		
	ORPORATION OF I	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
IAG		ulatory aids, when		IAG	,		DATE
	applicable.	natory aids, when					
	аррисаотс.						
	& Assess medic	ations administered that					
	increase risk of f						
	merease risk or r	annig.					
	9 Should fall or	ccur staff will notify					
	nurse immediate	·					
	naise minicalate	±J					
	13. IDT will me	et to discuss					
	individualized fa						
		ior Support Plan) or					
	,	ocols, when applicable."					
	other surety prot	ocois, when applicable.					
	Client C's record	l indicated the following					
		tes (not all inclusive):					
	in i wiceting not	ies (not un meiusive).					
	-11/6/14 Client (C's IDT met to follow up					
		visit. The IDT note					
		6/14 "[Client C] fell					
		getting out without					
		ance. The team decided					
	_	chair away from her bed					
	•	or help. Staff also have					
		ousemate not to try to					
	help without staf	•					
	ncip without star	i assistance					
	 _11/19/14	ient C] fell in the					
	bathroom trying	-					
		Staff will push [client C]					
		as soon as she gets off					
		et her to prevent future					
	falls."						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MUI A. BUILI B. WING	DING	00	(X3) DATE COMPL 01/21 /	ETED
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
VOCA C	ORPORATION OF	INDIANA			APOLIS, IN 46228		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	-12/15/14 "12/12 scratch on her he staff when they was tasted on her he investigation is the determine what 1-12/15/14- [Clies while completing Living skills). So wash out the fact some how lost be toilet. Staff assistance (Client Control of the completion of the	ead that was noticed by were brushing her hair. he fell. [Client C] is reself off the floor so an being conducted to happened. Int C] fell off the toilet g her ADL's (Adult Daily staff said she turned to be towel and [client C] alance and fell off the lad a gash on her ras taken to ER where and released. As a cod [client C] needs a seat belchair. The team also be toilet to prevent her cand the safety bars he toilet to prevent her cand alarm to alert staffing to get out the chair sic). If any of these cire HRC (Human Rights oval it will be obtained		IAG	DEPICIENCY)		DATE

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	e survey pleted 1/2015
	PROVIDER OR SUPPLIER		STREET A 4114 K	ADDRESS, CITY, STATE, ZIP CO NOLLTON RD IAPOLIS, IN 46228	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	injuries.					
	had fallen in the lately." Confide indicated staff w with client C wh bathroom. Confistated "She can't Confidential interview with stated a client a "sponge wash cloth off." Indicated client a stated "Not that a stated "Not that a stated a client a "sponge wash cloth off." Interview with staff #4 stated a client a "sponge wash cloth off." Interview with staff "Not that a stated a client a "sponge wash cloth off." Interview with staff #4 stated a client a "sponge wash cloth off." Interview with staff "Staff "Staff" when as on the floor before the stated that the stated a client a "sponge wash cloth off." Interview with staff "Staff" when as on the floor before the staff was a state of the state of t	erview A stated client C past, but had "no falls ntial interview A ere to be in the bathroom en she was in the idential interview A stand on her own." erview B stated when c C was to be tored in the bathroom, re. Help on commode. down and hold onto gait out and then she calls us e go back in there and hold onto gait belt." erview B indicated client a to the safety bar in the l. When asked how ll, confidential interview at much. She will jump hair unlocked and fall. leg and find her on floor." taff #4 on 1/14/15 at 7:35 fient C fell last month. staff was giving the off. Turned to rinse She (client C) fell on ked if client C had fallen re, staff #4 stated "Quite not fallen on my shift."				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	TIPLE CON	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	00	COMPL	
		15G447	B. WING			01/21/	2015
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I	ID	DECLIRATE OF A LIVER CONTROL OF		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Т	AG	DEFICIENCY)	_	DATE
W000331	#1, the QIDP and 3:35 PM indicaterisk. The QIDP facility staff were with client C who being toileted to falling. The QID client C's mobility did not indicate homoritor client C prevent potential. This federal tag is #IN00162396. 9-3-4(a) 483.460(c) NURSING SERVICE The facility must poservices in accord Based on observices in accord Pased on observices in accord review for (A and C), the facilients in regard revising risk plan significant changes.	rovide clients with nursing ance with their needs. ation, interview and r 2 of 4 sampled clients cility's nursing services e nursing needs of the to developing and/or ns, addressing a client's ge in weight (weight loss) ing pertinent health ients.	W0003	331	CORRECTION: The facility must provide clients with nursing services in accordance with their needs. Specifically for Client A, the facility nurse will contact the dietician to collaborate on enhancements to Client A's		02/20/2015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G447	B. WIN			01/21/2015
NAME OF L	DDOWNER OF GUIDNIE	S.D.	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIE	CK.		4114 K	NOLLTON RD	
VOCA C	ORPORATION OF	INDIANA		INDIAN	IAPOLIS, IN 46228	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	<u> </u>	DATE
					comprehensive High Risk Plan fo	r
	_	/13/15 observation period			Weight Loss. Additionally the	,
	between 5:04 PM and 6:45 PM, at the				interdisciplinary team will modify Client A's Behavior Support Plan	
	group home, cli	ient A was small in			to include proactive and reactive	
	stature. During	the 1/13/15 observation			strategies to address meal	
	period, client A	refused to eat dinner.			refusals.	
	•	offered the client a				
	_	n the client refused.				
		then offered the client				
	1				Specifically for Client C, the	
		t. Staff #7 told client A			facility nurse will modify Client C	
	` ′	ked pineapple. Client A			Comprehensive High Risk Plan for	
	-	ld eat the pineapple.			falls to clarify the expectations for "stand by" assistance while Clien	
	_	got the bowl of pineapple,			C is in the bathroom including but	
	client A refused	l to eat the pineapple and			not limited to hands on use of a	
	went to her bed	room before returning to			gait belt at all times while client	с
	the couch to pla	ny solitaire Uno.			is toileting and showering. The	
					team will also provide a modified	i
	During the 1/14	/15 observation period			toilet seat with side rails.	
	between 6:14 A	M and 8:30 AM, at the			Additional modifications may be	
		ient A refused to eat			made after Client C's scheduled	
		lity staff did not offer the			Occupational Therapy appointment. A review of incider	. +
		ate meal/food to eat.			documentation and current risk	11
		the mean rood to cat.			plans indicated this deficient	
	Client A's recer	d was reviewed on			practice did not affect any	
		0 PM. Client A's			additional clients.	
		physician's orders				
		A's diagnoses included,			DDFVENTION	
		nited to Diabetes Mellitus			PREVENTION:	
		lient A's December 2014			The QIDP will assure that the	
	physician's orde	ers indicated facility staff			nursing team is included in all	
	should encourage	ge "lower cholesterol			discussions/decisions relevant to	1
	snacks." The p	hysician's orders also			clients' health and safety and	
	indicated "Offe	r second servings of meat			modifications will be made to	
		have snack/sandwich			Comprehensive High Risk Plans	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DING	00	COMPL	ETED
		15G447	A. BUII B. WIN	LDING		01/21/	2015
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R		1	NOLLTON RD		
VOCA C	ORPORATION OF	ΙΝΠΙΔΝΔ			APOLIS, IN 46228		
					711 OLIO, 114 40220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
		luding during the night			accordingly. The nurse manager		
	_	ss." The December 2014			will review all reports of significant health and safety		
	physician orders	indicated client A			issues and will meet with the		
	should have 1 ca	n of Glucerna 4 times a			Operations Team weekly to		
	day as a nutrition	nal supplement and a			discuss health and safety issues		
	Glucerna bar at 1	lunch and at bedtime for			including but not limited to		
	a nutritional sup				needed updates to risk plans. Th	ie	
		F			nurse manager will review all		
	Client A's Nove	mber 2014 Nurse Notes			facility risk plan modifications for	-	
		the record) indicated			the next 90 days to assure they		
	`	· · · · · · · · · · · · · · · · · · ·			contain appropriate detail, and		
		d 83 pounds 1 month ago,			will conduct periodic audits of		
	•	onths ago and 100			facility risk plans on an ongoing		
	1 .	go. The 11/14 nurse note			basis.		
	did not have a cu	arrent weight for client					
	A. The area for	the "Current Weight"					
	was blank. The	nurse note indicated			RESPONSIBLE PARTIES:		
	client A's ideal b	oody weight range was					
	between 83 pour	nds and 101 pounds.			QIDP, Residential Manager, Tear	n	
	•	•			Leader, Health Services Team,		
	 Client A's 10/30	/14 Group Home			Direct Support Staff, Operations		
		sment indicated the			Team		
	following weigh						
	Tollowing weigh	is for Cheffit A.					
	-9/13 100 pound	S					
	-10/13 100 pound						
	-11/13 100 poun						
	_						
	-12/13 95 pound						
	-1/14 98 pounds						
	-2/14 100 pound						
	-3/14 96.6 pound						
	-4/14 95 pounds						
	-5/14 100 pound	s					
	-6/14 96 pounds						
	-7/14 "?" (questi	on) no weight					

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	OF CORRECTION IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 01/21/2015
	PROVIDER OR SUPPLIER ORPORATION OF INDIANA	4114 KN	NDDRESS, CITY, STATE, ZIP CODE NOLLTON RD APOLIS, IN 46228	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	documented -8/14 95 pounds 9/14 "?" no weight documented. The 10/30/14 assessment indicated client A's current weight at the time of the assessment was 83 pounds. The assessment indicated "Weight down likely d/t (due to) scale change but current BMI (Body Mass Index) is low/below the rec. (recommended) range. Resident receives Glucerna supplement QID (4 times a day) for additional nutrition. Underweight as evidenced by BMI < (less than) 18.5Goal -Weight gain of 2-3 # (pounds) x (times) 3 months BMI the rec. range (18.5-24.9)Cont (continue) diet orders (with) Glucerna QIDOffer snacks between meals and HS (bedtime) snack." Client A's 12/7/14 Individual Support Plan (ISP) indicated client A did not have a risk plan which addressed the client's low weight in her record. Client A's ISP and/or 12/7/14 Behavior Action Plan (BAP) did not address the client's refusals to eat, and/or indicate how/what the facility staff were to do to get client A to eat. Interview with LPN #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 1/14/15 at 3:35 PM indicated client A would refuse to eat. LPN #1			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G447	B. WIN			01/21/	2015
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					NOLLTON RD		
VOCA CO	ORPORATION OF I	NDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		A's current weight was 85					
	1 *	31/14. LPN #1 stated					
		0 pound weight loss" in					
		PN #1 stated the weight					
		ficant loss" for client A.					
		d she had not addressed					
	the client's weigl						
		A had a supplement drink					
	` ′	lient was to receive if the					
	client did not eat	and/or finfish her meal.					
	LPN #1 and the	QIDP indicated facility					
	staff should keep	prompting the client to					
	eat when she ref	used to eat. The QIDP					
	indicated client	A would not eat to get the					
	supplemental dri	nk as the client liked the					
	drink. The QIDI	P and LPN #1 indicated					
	client A's ISP die	d not indicate what					
	facility staff wer	e to do when client A					
	refused to eat, ar	nd/or indicate how					
	facility staff wer	e to assist client A to eat.					
	_						
	2. The facility's	reportable incident					
	reports, the facil	•					
		nt Reports (IARs) and/or					
		ere reviewed on 1/14/15					
		he facility's reportable					
	incident reports,	-					
	_	dicated the following					
	(not all inclusive						
	(1101 all lilotasive	· · · · · · · · · · · · · · · · · · ·					
	 -11/11/14 "Unon	arrival to group home					
		dividual Supported by					
]	t been assisted off the					
	'	group home by staff. As					
	van and mid the	group nome by starr. As					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE COMPL		
ANDILAN	OF CORRECTION	15G447	A. BUI	LDING	00	01/21/	
		130447	B. WIN			01/21/	2013
NAME OF F	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
VOCA C	ORPORATION OF	INDIANA			NOLLTON RD APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ed to assist the other					
		ne van (sic) [client C]					
		into the bathroom					
	_	omeone to assist her.					
		was in the bathroom she					
	_	e off her brief and pants					
	_	ll to her knees causing an					
	` '	diameter injury to the					
		area was cleaned with					
	•	tment applied to the area					
		n bandaide (sic)[Client					
	C] has a high ris	k plan for falls in place					
	and staff will co	ntinue to implement her					
	plan and give he	r moral support. The					
	interdisciplinary	team will be meeting to					
	determine other	ways to ensure [client					
	C's] safety."						
	-12/12/14 "As I	(staff #5) brushed [client					
	C's] head she wa	s complaining of pain on					
	her head where I	brushed. I asked her					
	what was wrong	(sic) she stated that she					
	fell as she got up	off the toilet and hit her					
		t seat." The IAR					
	indicated "The	re is a scratch that is a					
		is red and sore to the					
	touch (sic)."						
	, ,						
	The facility's 12	/31/14 follow-up report					
	<u>-</u>	reportable incident report					
		nt C's] injury has healed					
		edical treatment was					
		g the investigation it was					
		e staff that worked that					

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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA INDIANAPOLIS, IN 46228 SCHAMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG PRIFIX TAG P		T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447		LDING	NSTRUCTION 00	(X3) DATE COMPL 01/21 /	ETED
SUMMARY STATEMENT OF DEFICIENCIES TO PROVIDERS HLAN OF CORRECTION (CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PREDIX TAG PREGULATION OF LIST CENTER PRECEDED BY FULL TAG				•	4114 KN	NOLLTON RD	-	
PREFIX TAG REGULATORY OR IS DEPRECEDED BY FULL REGULATORY OR IS CIDENTIFYING INFORMATION, TAG PROGULATORY OR IS CIDENTIFYING INFORMATION. THE CHOICE SHEET COMMENTARY OF THE PROGULATION OF THE COMMENT OF THE COM		OKPORATION OF I	INDIANA		INDIAN	APOLIS, IN 46228		
bathroom into her bed with no injuries occurring that evening. [Client C] however said that she had fell (sic) and could not remember when she fell. Staff are being retrained on [client C's] high risk plan for falls and will monitor [client C] more closely." -12/15/14 "Staff was assisting [client C] (individual supported by ResCare) with using the toilet. Staff turned to the side to rinse a washcloth and [client C] fell off the commode and hit her head resulting in a 1/2 (one half inch) laceration. Staff called 911 and EMS (Emergency Medical Services) transported [client C] to the [name of hospital] for evaluation and treatment via ambulance. ER (emergency room) personnel closed and dressed the injury and released [client C] to ResCare staff with wound care instructions. [Client C] is resting comfortably at home and staff will perform neuro (neurological) checks for 24 hours per protocol. [Client C] has a history of falls and a Comprehensive High Risk Plan is in place, the risk plan for falls directs staff to provide her with stand-by assistance while transferring to and from the toilet"	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
An attached 12/15/14 Progress Note to the facility's 12/15/14 investigation		bathroom into he occurring that even however said that could not rememare being retrainerisk plan for falls C] more closely. -12/15/14 "Staff (individual supposition of the commode and in a 1/2 (one halt called 911 and E Services) transposition from the commode and in a 1/2 (one halt called 911 and E Services) transposition from the commode and in a 1/2 (one halt called 911 and E Services) transposition from the commode and in a 1/2 (one halt called 911 and E Services) transposition from the commode and treatment via among personnel injury and release staff with wound [Client C] is rest and staff will per (neurological) change of the risk staff to provide has sistance while the toilet"	er bed with no injuries rening. [Client C] at she had fell (sic) and aber when she fell. Staff ed on [client C's] high and will monitor [client "" was assisting [client C] orted by ResCare) with Staff turned to the side toth and [client C] fell off d hit her head resulting f inch) laceration. Staff EMS (Emergency Medical borted [client C] to the all for evaluation and abulance. ER (emergency closed and dressed the ted [client C] to ResCare I care instructions. In a comfortably at home rform neuro necks for 24 hours per the C] has a history of falls insive High Risk Plan is plan for falls directs her with stand-by transferring to and from					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	ETED
		15G447	B. WIN			01/21/2	2015
NAME OF F	DOLUBED OD GUDDU IED		-	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L		4114 KN	NOLLTON RD		
	ORPORATION OF I	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nt C] had Nasty fall in the					
	bathroom this AM, while being assist (sic) by staff member. Slid down off						
	toilet as staff wa	s trying to wash her.					
	[Client C] fell fo	rward and hit her head.					
	Nurse was called	l and she stated to call					
	emerg. (emergen	ncy). She was then taken					
	to Hosp. (hospita	al) for observation." The					
		gation indicated "IDT					
	(interdisciplinary						
	`	ferent ways to help					
		lls such as seat belt for					
	_	ped alarm to alert staff					
		ing out of bed or chair					
	without assistant	_					
		from ER physician to					
		(Physical Therapy) apt.					
	(appointment)."						
	Client C's record	l was reviewed on					
	1/14/15 at 1:16 I	PM. Client C's 12/15/14					
	Record Of Visit	(ROV) indicated client C					
		eal hospital due to a fall.					
		ted client C had a					
		ation. Normal head CT					
		ervical spine CT. Keep					
	` ′	• •					
	wound dry for 24 hours then wash as usual. Watch for signs of infection.						
		•					
		for strengthening and					
	fall prevention."						
	Client C's 12/12/	14 ROV indicated client					
	C was seen at EI	R due to a fall. The ROV					
	indicated "Fronta	al Forehead bruising &					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 01/21 /	ETED
	PROVIDER OR SUPPLIER		B. WIW	STREET A	ODDRESS, CITY, STATE, ZIP CODE NOLLTON RD APOLIS, IN 46228	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	(and) Abrasion. contusion/Abras instructions. Ty	ion. Head Injury					
	the facility's nurshome to assess of from the ER. The the nurse had was transfer the clienthe bed and from commode using assist with the traindicated "Compiece of gauze of forehead from fatransparent medit that while in the used a glue-like wound together. the ER doctor has the area until the the wound was a inch in lengthCoduring the IDT in discovered that is in her wheelchai in order to do this notes and/or reconurse failed to de PT evaluation has	cal tape. Staff reported ER, the doctor there substance to close the Staff also reported that d advised not to cleanse next day. The size of pprox. (approximately) 1 Consumer was present neeting, and it was he 'scoots' herself around r, but she leans forward s." Client C's nurse ord indicated the facility's ocument when and/or if a d been set up/scheduled.					
		4 Health Supports ated client C has an					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G447	B. WIN	G		01/21/	2015
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
\/OOA O/		INITHANIA			NOLLTON RD		
	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		The addendum indicated		ing	·		DATE
	, , ,	lient C] has had several					
		alt of falls; therefore					
	[client C] currently utilizes a wheelchairEven though [client C]						
		chair, she still continues					
		oting to use it properly					
		stance to move into seats					
		hairShe will continue					
		luation annually"					
	to have a 1 1 eva	ination annually					
	Client C's 5/13/1	4 Individual Support					
	Plan (ISP) indica	ated "3.) [Client C]					
	does not utilize p	proper precautions when					
	ambulating her v	wheelchair, despite staff					
	_	therwise. She needs					
	several redirection	ons to make sure her seat					
	belt is fasten, the	e team agreed to continue					
	this goal (to utili	ze her wheelchair in an					
	appropriate man	ner). 4.) [Client C] is still					
	having slight pro	oblems in asking for					
	assistance in doi	ng things that require her					
		wheelchairIn the past,					
	[client C] has be	en noted as falling when					
	trying to move o	out of her wheelchair."					
	Client C's undate	ed Decreased Mobility					
	High Risk Healt	h Plan indicated client C					
		ir for all mobility. The					
		ed "4. Staff to provide					
		nce when entering and					
	exiting the van.	5. Staff to provide					
	standby assistan	ce during in home					
	ambulation exer	cises. 6. Staff to provide					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G447	B. WIN			01/21/2015
NAME OF B	DROWNER OF GUIDNIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	s		4114 KI	NOLLTON RD	
	ORPORATION OF I			INDIAN	APOLIS, IN 46228	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	at least standby a	•				
		ng/toileting. 7. Should				
	fall occur NOTIFY the nurse immediately"					
	Client C's record	indicated client C had				
		ed policy titled FALL				
		PROTOCOL in the				
		The undated policy				
		CY: Falls occur among				
		•				
	people who are v					
		aralyzed, confused or				
		data obtained from the				
		ent will identify which				
	individuals requi	ire special measures to				
	prevent falls. Th	ne risk for falls can be				
	reduced by sever	al factors as outlined				
	below.					
	PROCEDURE:					
	1 Staff should o	orient the person to the				
	environment.	ment the person to the				
	onvironinciit.					
	2. Staff should p	provide nonskid				
	footwear, mats a					
	100tm cai, iliatis a	114 1 450.				
	3. Adequate ligh	nting in the environment.				
	4. Close supervi	sion, when applicable.				
		lowest appropriate				
	position as defin	ed by the IDT.				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 01/21	ETED
	PROVIDER OR SUPPLIER		•	4114 KN	DDRESS, CITY, STATE, ZIP CODE NOLLTON RD APOLIS, IN 46228		
				L,	APOLIS, IN 40220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	6. Side rails up i	f applicable.					
	7. Provide ambu applicable.	llatory aids, when					
	8. Assess medic increase risk of f	ations administered that alling.					
	9. Should fall or nurse immediate	ecur staff will notify ly					
	Client C's record IDT Meeting not -11/6/14 Client C on falls and ER v indicated on 7/26 out (sic) the bed asking for assistato put her wheeld so she can call for	all prevention per ior Support Plan) or ocols, when applicable." I indicated the following tes (not all inclusive): C's IDT met to follow up visit. The IDT note 6/14 "[Client C] fell getting out without ance. The team decided chair away from her bed or help. Staff also have ousemate not to try to					
		-					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		15G447	B. WIN			01/21/	2015
NAME OF I			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		4114 KI	NOLLTON RD		
	ORPORATION OF				APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE
		st her to prevent future					
	falls."						
	12/15/14 "12/1	2/14 [Client Cl had a					
	-12/15/14 "12/12/14 - [Client C] had a scratch on her head that was noticed by staff when they were brushing her hair.						
	1	•					
		he fell. [Client C] is					
	_	rself off the floor so an					
	_	being conducted to					
	determine what						
	_	nt C] fell off the toilet					
	_	g her ADL's (Adult Daily					
		staff said she turned to					
		e towel and [client C]					
		alance and fell off the					
		sted [client C] off the					
		had a gash on her					
		vas taken to ER where					
		and released. As a					
	•	od [client C] needs a seat					
		elchair. The team also					
	_	t C] having her gait belt					
		ner and the safety bars					
		he toilet to prevent her					
		C] would also benefit					
		chair alarm to alert staff					
	1	ng to get out the chair					
	with assistance (sic). If any of these					
	suggestions requ	ire HRC (Human Rights					
		oval it will be obtained					
	after this plan is	reviewed by the					
	management cor	nmittee." Client C's					
	above mentioned	d IDT meeting notes, ISP					
	and/or record in	dicated the facility's					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447		ULTIPLE CO LDING	nstruction 00	(X3) DATE SURVEY COMPLETED 01/21/2015	
		130447	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	01/21/2013	
NAME OF P	PROVIDER OR SUPPLIEF	3			NOLLTON RD		
	ORPORATION OF	INDIANA			APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(XS	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLE DATE	
-	nursing services	failed to develop a					
	specific risk plan in regard to client C's falls which indicated how facility staff were to monitor/supervise client C while						
		to prevent potential falls					
	and/or injuries.	to prevent potential fails					
	and/or injuries.						
	Confidential inte	erview A stated client C					
		past, but had "no falls					
		ential interview A					
	indicated staff w	vere to be in the bathroom					
	with client C wh	nen she was in the					
	bathroom. Conf	idential interview A					
	stated "She can't	stand on her own."					
		erview B stated when					
	asked how clien						
	_	tored in the bathroom,					
	_	re. Help on commode.					
		down and hold onto gait					
		out and then she calls us					
	1	e go back in there and hold onto gait belt."					
		erview B indicated client					
		n to the safety bar in the					
	bathroom as wel	•					
	Interview with s	taff #4 on 1/14/15 at 7:35					
	AM indicated cl	ient C fell last month.					
		staff was giving the					
		off. Turned to rinse					
		She (client C) fell on					
		ked if client C had fallen					
	on the floor before	ore, staff #4 stated "Quite					

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AND PLAN OF CORRECTION IDE		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		COM	(X3) DATE SURVEY COMPLETED 01/21/2015		
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	a few times, but Interview with C #1, the QIDP and 3:35 PM indicate risk. When aske the toilet, the QID forward and fell. client C's IDT m and made recom and the QIDP ind see the PT on 1/3 LPN #1 indicate recommendation and wheelchair/b purchased as the evaluation to be and LPN #1 indi to stay in the bat when she was ba to prevent the cli asked if client C' updated, LPN sta and LPN #1 indi risk plan and/or in how facility staff C when in the ba potential falls an This federal tag in #IN00162396.	Interpretation of the property		CROSS-REFERENCED TO THE	ÄPPROPRIATE			
	9-3-6(a)							

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/21/2015		
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		TE	(X5) COMPLETION DATE

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